

Northern Lincolnshire and Goole NHS Foundation Trust

Inspection report

Diana Princess Of Wales Hospital
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Ratings

Overall trust quality rating

Requires improvement 

Are services safe?

Inadequate 

Are services effective?

Requires improvement 

Are services caring?

Good 

Are services responsive?

Requires improvement 

Are services well-led?

Requires improvement 

Are resources used productively?

Requires improvement 

Combined quality and resource rating

Requires improvement 

Our reports

We plan our next inspections based on everything we know about services, including whether they appear to be getting better or worse. Each report explains the reason for the inspection.

Summary of findings

This report describes our judgement of the quality of care provided by this trust. We based it on a combination of what we found when we inspected and other information available to us. It included information given to us from people who use the service, the public and other organisations.

This report is a summary of our inspection findings. You can find more detailed information about the service and what we found during our inspection in the related Evidence appendix.

Background to the trust

Northern Lincolnshire and Goole NHS Foundation Trust was established as a combined hospital trust on 1 April 2001 and achieved foundation status on 1 May 2007. It was formed by the merger of North East Lincolnshire NHS Trust and Scunthorpe and Goole Hospitals NHS Trust and operates all NHS hospitals in Scunthorpe, Grimsby and Goole. In April 2011 the trust became a combined hospital and community services trust (for North Lincolnshire).

The trust provides a range of hospital-based and community services to a population of more than 400,000 people across North and North East Lincolnshire and East Riding of Yorkshire.

The trust has approximately 850 inpatient and critical care beds across 44 wards, 120,000 inpatient episodes, and saw over 360,000 outpatient appointments. The trust employs around 6,500 members of staff.

The trust operates from three hospital sites;

- Diana, Princess of Wales Hospital
- Scunthorpe General Hospital
- Goole and District Hospital

The trust provides the following community health services in North Lincolnshire;

- Adults
- Dental
- End of life care

North Lincolnshire Clinical Commissioning Group (CCG), North East Lincolnshire CCG and East Riding of Yorkshire CCG commission the majority of the trust's services, based on the needs of their local populations.

The CQC has carried out a number of inspections of the trust; the last comprehensive inspection of the acute services was in 8-11 May 2018 with an unannounced focused inspection carried out on 23 May 2018. The report was published in September 2018 and overall the trust was rated as requires improvement with safe, effective and responsive being rated as requires improvement and caring rated as good.

We carried out a comprehensive inspection of urgent and emergency care, medical care, surgery, critical care, maternity, services for children and young people, outpatients, diagnostic imaging, acute and community end of life care, community adults and dental from 24 to 27 September 2019. We carried out an unannounced inspection on the 10 October 2019.

Our rating of this trust stayed the same since our last inspection. We rated it as Requires improvement



Summary of findings

What this trust does

Northern Lincolnshire and Goole NHS Foundation Trust has approximately 850 inpatient and critical care beds across 44 wards, 120,000 inpatient episodes, and saw over 360,000 outpatient appointments. The trust employs around 6,500 members of staff.

The trust operates from three hospital sites;

- Diana, Princess of Wales Hospital acute
- Scunthorpe General Hospital select
- Goole and District Hospital

The two main sites DPoW and SGH provide a full range of acute services.

Goole and district provides elective surgical care, midwifery, diagnostics, outpatients and medical care services.

The trust provides the following community health services in North Lincolnshire;

- Adults
- Dental
- End of life care

Key questions and ratings

We inspect and regulate healthcare service providers in England.

To get to the heart of patients' experiences of care and treatment, we ask the same five questions of all services: are they safe, effective, caring, responsive to people's needs, and well-led?

Where we have a legal duty to do so, we rate the quality of services against each key question as outstanding, good, requires improvement or inadequate.

Where necessary, we take action against service providers that break the regulations and help them to improve the quality of their services.

What we inspected and why

We plan our inspections based on everything we know about services, including whether they appear to be getting better or worse.

We inspected all services provided by this trust because at our last inspection in May 2018 we rated the trust overall as requires improvement, however well led was rated as inadequate. Following this last inspection the trust remained in special measures.

Our comprehensive inspections of NHS trusts have shown a strong link between the quality of overall management of a trust and the quality of its services. For that reason, all trust inspections now include inspection of the well-led key question for the trust overall. What we found is summarised in the section headed Is this organisation well-led?

Between 24-27 September 2019 we carried out a comprehensive inspections across all three hospital locations and community. On the 10 October 2019 we carried out an unannounced focussed inspection. This inspection is part of our continual checks on the safety and quality of healthcare services.

What we found

Summary of findings

Overall trust

Our rating of the trust stayed the same. We rated it as requires improvement because:

- We rated safe as inadequate. We rated effective, responsive and well led as requires improvement. We rated caring as good.
- Our rating of Diana Prince of Wales Hospital stayed the same. We rated it as requires improvement. Of the nine services we inspected, we rated three as inadequate and we rated six services as requires improvement.
- Our rating of Scunthorpe General Hospital stayed the same. We rated it as requires improvement. Of the nine services we inspected, we rated three as inadequate, five as requires improvement and one as good.
- Our rating of Goole and District Hospital stayed the same. We rated it as requires improvement. Of the five services we inspected, we rated two as inadequate and three as good. Our decisions on overall ratings take into account the relative size of services. We have used our professional judgement to reach fair and balanced ratings.
- Our rating of the trust's community services stayed the same. We rated community health services as requires improvement. We rated one of the three services as requires improvement and two as good.
- We rated well-led for the trust overall as required improvement.
- We rated the trust's use of resources as requires improvement.

Are services safe?

Our rating of safe went down. We rated it as inadequate because:

- There had been incidents where patients had come to harm due to delays in receiving appointments in both outpatients and diagnostic imaging. We had concerns regarding this and after the inspection, the Care Quality Commission completed a section 31 letter of intent to seek further clarification from the trust.
- Across most services there was still insufficient numbers of staff within the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment.
- The service provided mandatory training in key skills to staff but had not ensured everyone had complete it. Across most services there were continued low levels of mandatory training.
- We had ongoing concerns that patients with mental health conditions were not always cared for in a safe environment.
- Within the emergency department there were significant numbers of black breaches and the department failed to meet the medium time to initial assessment.
- The services did not always manage infection control risks.

However:

- On the whole the services managed incidents well and there was evidence that there was shared learning
- They managed medicines well. We saw improvements in the safe administration and storage and handling of medicine management.

Are services effective?

Our rating of effective stayed the same. We rated it as requires improvement because:

- The services did not always provide care and treatment in line with national guidance and best practice. We found examples of this in some of the core services inspected.

Summary of findings

- The services did not ensure that staff were competent to carry out their roles and compliance with annual appraisals continued to be low.
- Within end of life we were concerned about the timeliness of pain relief given to patients and lack of documentation which would enable to trust to monitor the effectiveness of care and treatment and drive improvement.
- Key services were not always available for seven days a week.
- Managers did not always monitor the effectiveness of the services and use patient outcomes to drive improvement.

However:

- Staff ensured that patients had enough to eat and drink and advised them how to lead a healthier lifestyle.

Are services caring?

Our rating of caring stayed the same. We rated it as good because:

- Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs. We observed many interactions between staff, patients and others during our inspection. We found most staff to be polite, respectful, professional and non-judgmental in their approach
- Most staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs. Patients told us they felt very well supported and said staff were attentive and listened to their needs.
- Most staff supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment. Patients and those close to them told us they felt involved in the planning and implementation of care and they had been given clear information.

Are services responsive?

See guidance note 6 then add your text after the standard text paragraph below (and delete this help text).

Our rating of responsive stayed the same. We rated it as requires improvement because:

- Within outpatients continued backlogs were identified and within diagnostic imaging there was also an increased backlog of patient awaiting diagnostic image services and the subsequent reporting of x-rays.
- Services were not always planned to meet the needs of local services. This was particularly so in end of life services.
- Waiting times, referral to treatment and arrangements to admit, treat and discharge across a number of core services continued to be a challenge. People could not always access the services when they needed to.
- Investigations of complaints were not managed in a timely way and in line with trust policy.

However:

- Staff took account of patients individual needs and made it easier for people to give feedback.

Are services well-led?

Our rating of well-led improved. We rated it as requires improvement because:

- The systems to manage of risk, issues and performance had improved.
- More effective governance processes had just been implemented and were evolving, throughout the trust and with partner organisations.

Summary of findings

- Overall staff felt respected, supported and valued. The trust was developing a more open culture where patients, their families and staff could raise concerns without fear but there was more work needed to ensure this became fully embedded.
- Most services had an open culture where patients, their families and staff could raise concerns without fear.
- The trust was focused on the needs of staff and patients receiving care. Equality and diversity was promoted in daily work and provided opportunities for career development.

However, we still had ongoing concerns that:

- More pace was needed to deliver improvements at core service level within the trust.
- Across most services there was a continued lack of clear strategies at this level. Although services had a vision for what they wanted to achieve there was a lack of supporting and enabling strategies.
- Systems to manage performance were not consistently used to improve performance.
- Some services identified and escalated relevant risks. However, the identification of issues and actions to reduce the impact of risks were still not embedded and some risks had not been managed in a timely manner.
- The services did not always collect reliable data, analyse and use it to make improvements.
- There continued to be changes in the governance structures and processes which had not become embedded and therefore there was limited oversight.
- There was limited evidence of continuous improvement and innovation across most core services.

Ratings tables

The ratings tables show the ratings overall and for each key question, for each service, hospital and service type, and for the whole trust. We took all ratings into account in deciding overall ratings. Our decisions on overall ratings also took into account factors including the relative size of services and we used our professional judgement to reach fair and balanced ratings.

Areas for improvement

We found areas for improvement including seven breaches of legal requirements that the trust must put right. We also found things that the trust should improve to comply with a minor breach that did not justify regulatory action, to prevent breaching a legal requirement, or to improve service quality.

For more information, see the Areas for improvement section of this report.

Action we have taken

We wrote to the trust once under Section 31 of the Health and Social Act 2008 to consider whether to use CQC's regulatory powers to impose or vary registration conditions. We did this because we had reasonable cause to believe that, unless CQC acted people would be or may have been exposed to the risk of harm. The letter was in relation to the incidents where patients had come to harm due to delays in receiving appointments in both outpatients and diagnostic imaging. The trust responded to the letter and provided detailed information on how they are going to manage the issues detailed in the Section 31 letter of intent. CQC will continue to monitor this.

We issued requirement notices to the trust. That meant the trust had to send us a report saying what action it would take to meet these requirements.

For more information on action we have taken, see the sections on areas for improvement and regulatory action.

Summary of findings

What happens next

We will check that the trust takes the necessary action to improve its services. We will continue to monitor the safety and quality of services through our continuing relationship with the trust and our regular inspections.

Outstanding practice

Areas for improvement

Action the trust **MUST** take is necessary to comply with its legal obligations.

Action the trust **MUST** take to improve:

We told the trust that it must take action to bring services into line with seven legal requirements.

This action related to the following services.

Trustwide

- The trust must ensure they have evidence to show that complete employment checks for executive and non-executive staff have been taken in line with the Fit and Proper Persons Requirement (FPPR) (Regulation 5).
- The trust must ensure that effective and robust systems are in place to support the management of governance, risk and performance. (Regulation 17)
- The trust must continue its work to improve its reporting of performance information to enable easier oversight and governance and continue its work to improve its digital systems and processes. (Regulation 17)
- The trust must develop a clinical and financial strategy that addresses the delivery of safe and sustainable services. (Regulation 17)
- The trust must ensure complaints are addressed in line with the trust policy. (Regulation 16)

Action the trust **MUST** take to improve in urgent and emergency services:

Scunthorpe General Hospital

- The service must ensure staff meet the mandatory training standards (Regulation 12).
- The service must ensure they appropriately recruit staff specifically registered sick children's nurses (RSCN) to meet the Intercollegiate Emergency Standard of two RSCN's per shift (Regulation 18).
- The service must ensure they appropriately recruit medical staff to meet the Royal College of Emergency Medicine (RCEM) guidance of providing 16 hour consultant cover (Regulation 18).
- The service must ensure the mental health assessment room meets the Psychiatric Liaison Accreditation Network (PLAN) standards (Regulation 12).
- The service must ensure all staff have up to date appraisals. (Regulation 12)

Diana Princess of Wales Hospital

- The trust must continue to appropriately recruit medical staff to ensure that there are sufficiently suitably qualified, competent and experienced staff on duty to meet the needs of patients. The department was not in line with the Royal College of Emergency Medicine (RCEM) guidance of providing 16 hour consultant cover. (Regulation 18)

Summary of findings

- The trust must ensure that all staff complete mandatory training to meet the trust's set standard of 85%. (Regulation 12)
- The trust must ensure that all staff have an up to date appraisal completed. (Regulation 12)
- The trust must continue to appropriately recruit staff (specifically registered sick children's nurses (RSCN) and ensure that there are sufficiently suitably qualified, competent and experienced staff on duty to meet the needs of patients. The emergency department was not meeting the Intercollegiate Emergency Standard to have sufficient RSCNs to provide two per shift. (Regulation 18)
- The trust must ensure that the mental health room is compliant with the Psychiatric Liaison Accreditation Network (PLAN) standards. (Regulation 12)
- The trust must ensure that oxygen is prescribed appropriately to all patients. (Regulation 12)

Action the trust MUST take to improve in medical care:

Scunthorpe General Hospital

- The service must continue to monitor registered nurse establishment on the respiratory ward (ward 22) and the hyper acute stroke unit (HASU) to ensure adherence to best practice in line with national guidance recommendations of one nurse to two patients. (Regulation 12).
- The service must ensure that mandatory training compliance, including safeguarding training, Mental Capacity Act and Deprivation of Liberty Safeguards training, meets the trust target. (Regulation 12).
- The service must ensure oxygen for patients is prescribed, in line with national guidance. (Regulation 12).
- The service must ensure that confidential records are stored securely in line with national guidance. (Regulation 17)
- The service must continue to monitor referral to treatment times and the average length of patient stay for elective and non-elective specialties against the England average. (Regulation 17)
- The service must ensure that all staff receive an appraisal. (Regulation 12)

Diana Princess of Wales Hospital

- The service must ensure mandatory training compliance, including safeguarding training and Mental Capacity Act and Deprivation of Liberty Safeguards training, meets the trust target. (Regulation 12)
- The service must ensure safe medicines management in all areas, specifically in relation to recording of controlled drugs' prescriptions, storage of medicines in the escalation area and prescription of oxygen therapy. (Regulation 12)
- The trust service continue to monitor referral to treatment times to improve performance standards measured against the England average. (Regulation 17)
- The trust service ensure that confidential paper records are stored and disposed of securely in line with national guidance. (Regulation 17)
- The trust service ensure robust oversight and management of the escalation area adjacent to the acute medical unit. (Regulation 17)
- The service must ensure that all staff receive an appraisal. (Regulation 12)

Goole and District Hospital

- The service must ensure all staff, but medical staff in particular, are up to date with their mandatory training. (Regulation 18)

Summary of findings

- The service must ensure the vision and strategy for medicine is finalised promptly. (Regulation 17)

Action the trust MUST take to improve in surgery:

Scunthorpe General Hospital

- The service must continue to monitor and take action to reduce mixed sex accommodation breaches. (Regulation 9).
- The service must ensure that consent is gained in accordance with best practice and legal requirements. (Regulation 11)
- The service must ensure medical and nursing staff comply with mandatory training, safeguarding and mental capacity training requirements and are appraised annually. annually (Regulation 12).
- The service must ensure that policies and guidelines in use within clinical areas are compliant with National Institute for Health and Care Excellence (NICE) or other clinical bodies (Regulation 12).
- The service must continue to meet national treatment performance standards in all specialities (Regulation 12).
- The service must continue to make improvements to surgical pathways to theatre and improve the pre-assessment pathways and compliance and reduce the number of cancelled operations. (Regulation 12).
- The service must ensure that effective processes are in place to enable access to theatres and that all cases are prioritised appropriately (Regulation 12).
- The service must improve the compliance of documenting fluid balance intake accurately (Regulation 12).
- The service must improve response times to complaints in line with their own policy (Regulation 16)
- The service must improve the quality and timeliness of response to incidents and oversight of incident themes and trends to improve the quality of patient care (Regulation 17)
- The service must ensure that all documentation is reviewed, version controlled and completed accurately to safely document the needs of the patient (Regulation 17)
- The service must continue to improve governance processes to ensure that risks and performance concerns are discussed, documented and acted upon in a consistent manner (Regulation 17)
- The service must continue to define and complete the strategy for surgical services in conjunction with key stakeholders (Regulation 17)

Diana Princess of Wales Hospital

- The service must continue to monitor and take action to reduce mixed sex accommodation breaches (Regulation 9).
- The service must ensure that consent is gained in accordance with best practice and legal requirements (Regulation 11)
- The service must ensure medical and nursing staff comply with mandatory training, safeguarding and mental capacity training requirements and are appraised annually (Regulation 12).
- The service must ensure that policies and guidelines in use within clinical areas are compliant with National Institute for Health and Care Excellence (NICE) or other clinical bodies (Regulation 12).
- The service must ensure patients on the pre-assessment ward have access to an emergency call system (Regulation 12).

Summary of findings

- The service must ensure staff are aware of the resuscitation procedure on the pre-assessment ward and know where to access the required equipment and there were systems and processes in place to manage a deteriorating patient (Regulation 12).
- The service must continue to meet national treatment performance standards in all specialities (Regulation 12).
- The service must continue to make improvements to surgical pathways to theatre and improve the pre-assessment pathways and compliance and reduce the number of cancelled operations (Regulation 12).
- The service must ensure that effective processes are in place to enable access to theatres and that all cases are prioritised appropriately (Regulation 12).
- The service must ensure that patients are fasted pre-operatively in line with best practice recommendations (Regulation 12).
- The service must improve the compliance of documenting malnutrition universal screening tool (MUST) to identify patients at risk in line with trust policy (Regulation 12).
- The service must improve response times to complaints in line with their own policy (Regulation 16)
- The service must improve the quality and timeliness of response to incidents and oversight of incident themes and trends to improve the quality of patient care (Regulation 17)
- The service must ensure that all documentation is reviewed, version controlled and completed accurately to safely document the needs of the patient (Regulation 17)
- The service must continue to improve governance processes to ensure that risks and performance concerns are discussed, documented and acted upon in a consistent manner (Regulation 17)
- The service must continue to define and complete the strategy for surgical services in conjunction with key stakeholders (Regulation 17)

Goole and District Hospital

- The service must continue to define and complete the strategy for surgical services in conjunction with key stakeholders. (Regulation 17)
- The service must improve response times to complaints in line with their own policy. (Regulation 16)

Action the trust MUST take to improve in critical care:

Scunthorpe General Hospital

- The service must ensure that there is a dedicated supernumerary care co-ordinator at all times (Regulation 18).
- The service must ensure that there is a dedicated on call intensivist for ICU at Scunthorpe General Hospital during the night and weekends. (Regulation 18).
- The service must ensure consultant cover has continuity and consistency for patients and their individual plans. (Regulation 18)

Diana Princess of Wales Hospital

- The service must ensure that at least 50% of nursing staff hold a post graduate qualification in critical care nursing to meet the GPICS standards. (Regulation 18).
- The service must ensure that there is a dedicated supernumerary care co-ordinator at all times (Regulation 18).

Summary of findings

- The service must ensure that there is a dedicated on call intensivist for ICU at DPoW during the night and weekends. (Regulation 18).
- The service must ensure consultant cover has continuity and consistency for patients and their individual plans. (Regulation 18)
- The p service must ensure that the equipment used by the service for providing care or treatment to a service user is safe for such use and used in a safe way. (Regulation 12)
- The service must ensure the proper and safe management of medicines. (Regulation 12)

Action the trust MUST take to improve in maternity:

Scunthorpe General Hospital

- The service must ensure all staff are up to date with mandatory training, including obstetric emergency training, resuscitation training, adults safeguarding training and Mental Capacity and Deprivation of Liberty Safeguards training. In addition, that quarterly 'live' emergency skills and drills training is provided, in line with trust policy. (Regulation 18)
- The service must ensure they thoroughly review maternity staffing requirements across the service, make sure community midwifery staffing caseloads are in line with national guidance, mitigate against the risks of short staffing due to sickness absence, and limit the cancellation of clinics. (Regulation 18)
- The service must ensure a duty anaesthetist is immediately available to cover emergency work on delivery suite, in line with trust policy and national guidelines. (Regulation 18)
- The trust must ensure that all staff receive an annual appraisal. (Regulation 18)
- The service must ensure good governance of the service. Including, ensuring the frequency of perinatal morbidity and mortality meetings is compliant, NICE 'red flag' and other key performance data is systematically recorded and reliable, and committee meeting minutes, and action plans are sufficiently robust. (Regulation 17)
- The service must ensure the time taken to investigate and close complaints is in line with the trust's complaints policy. (Regulation 16)
- The service must ensure the risk of delayed access to the central deliver suite and theatres for women on the antenatal / postnatal ward is minimised. (Regulation 12)

Diana Princess of Wales Hospital

- The service must ensure all staff are up to date with mandatory training, including obstetric emergency training, resuscitation training, adults safeguarding training, and Mental Capacity and Deprivation of Liberty Safeguards training. In addition, that quarterly 'live' emergency skills and drills training is provided, in line with trust policy. (Regulation 18)
- The service must ensure they thoroughly review maternity staffing requirements across the service, make sure community midwifery staffing caseloads are in line with national guidance, mitigate against the risks of short staffing due to sickness absence, and limit the cancellation of clinics. (Regulation 18)
- The service must ensure that there is an independent registered scrub nurse able to supervise in theatres at all times, in line with national standards. (Regulation 18)
- The service must ensure that all staff receive an annual appraisal. (Regulation 18)

Summary of findings

- The service must ensure good governance of the service. Including, ensuring the frequency of perinatal morbidity and mortality meetings is compliant, NICE 'red flag' and other key performance data is systematically recorded and reliable, and committee meeting minutes, and action plans are sufficiently robust. (Regulation 17)
- The service must ensure the time taken to investigate and close complaints is in line with the trust's complaints policy. (Regulation 16)

Goole and District Hospital

- The service must ensure they thoroughly review maternity staffing requirements across the service, make sure community midwifery staffing caseloads are in line with national guidance, mitigate against the risks of short staffing due to sickness absence, and limit the cancellation of clinics. (Regulation 18)
- The service must ensure all staff are up to date with mandatory training, including resuscitation training, adults safeguarding training, skills and drills training (to include a pool evacuation drill), and Mental Capacity and Deprivation of Liberty Safeguards training. (Regulation 18)

Action the trust MUST take to improve in services for children and young people:

Scunthorpe General Hospital

- The service must ensure that children and young people with a mental health condition at Scunthorpe general hospital are risk assessed for their mental health needs, self-harm or suicide and are cared for in a safe environment that has been appropriately risk assessed. (Regulation 12)
- The service must ensure that nurse staffing at Scunthorpe general hospital on the paediatric assessment unit meets national guidance. (Regulation 18)
- The service must ensure that staff at Scunthorpe general hospital are appropriately trained in caring for children and young people with mental health conditions. (Regulation 12)
- The service must ensure that they are meeting national standards for medical staffing at Scunthorpe general hospital. (Regulation 18)
- The service must ensure that medical staff complete MCA training in accordance with trust targets. (Regulation 12)

Diana Princess of Wales Hospital

- The trust must ensure that children and young people with a mental health condition are risk assessed for their mental health needs, self-harm or suicide and are cared for in a safe environment that has been appropriately risk assessed. (Regulation 12)
- The trust must ensure that staffing on the paediatric assessment unit meets national guidance. (Regulation 18)
- The trust must ensure that staff are appropriately trained in caring for children and young people with mental health conditions. (Regulation 12)
- The trust must ensure that they are meeting national standards for medical staffing. (Regulation 18)
- The trust must ensure that controlled drug registers are completed correctly, and regular audits carried out. (Regulation 12)

Action the trust MUST take to improve in end of life care:

Scunthorpe General Hospital

- The service must ensure equipment used to deliver end of life and palliative care are used in accordance with trust policy and national best practice. (Regulation 12)

Summary of findings

- The service must ensure that there are sufficient staff with the right qualifications, skills and training to keep people safe from harm. (Regulation 12)
- The service must ensure that patient records are completed consistently and appropriately. (Regulation 12)
- The service must ensure safe medicines management in all areas, specifically in relation to reviewing and monitoring of analgesia. (Regulation 12)
- The service must ensure robust oversight and management of incidents and ensure incidents are shared across the speciality. (Regulation 12)
- The service must ensure clinical care and treatment are delivered in accordance with national guidance and best practice. (Regulation 17)
- The service must ensure that robust systems are in place to monitor the effectiveness of care and treatment delivered to achieve good outcomes for patients. (Regulation 17)
- The service must ensure that all complaints are managed in accordance with trust policy. (Regulation 16)
- The service must ensure robust governance processes are in place to lead, manage, risk assess and sustain effective services. (Regulation 17)

Diana Princess of Wales Hospital

- The service must ensure equipment used to deliver end of life and palliative care are used in accordance with trust policy and national best practice. (Regulation 12)
- The service must ensure that there are sufficient staff with the right qualifications, skills and training to keep people safe from harm. (Regulation 12)
- The service must ensure that patient records are completed consistently and appropriately. (Regulation 12)
- The service must ensure safe medicines management in all areas, specifically in relation to reviewing and monitoring of analgesia. (Regulation 12)
- The service must ensure robust oversight and management of incidents and ensure incidents are shared across the speciality. (Regulation 12)
- The service must ensure clinical care and treatment are delivered in accordance with national guidance and best practice. (Regulation 17)
- The service must ensure that robust systems are in place to monitor the effectiveness of care and treatment delivered to achieve good outcomes for patients. (Regulation 17)
- The service must ensure staff treat patients with compassion, kindness and respect and take account of individual needs. (Regulation 17)
- The trust must ensure that all complaints are managed in accordance with trust policy. (Regulation 16)
- The service must ensure robust governance processes are in place to lead, manage, risk assess and sustain effective services. (Regulation 17)

Action the trust MUST take to improve in outpatients:

Scunthorpe General Hospital

- The service must continue to address the challenges regarding overdue new and follow up appointments and ensure patients receive their appointment in a timely way across outpatient specialties. (Regulation 12).

Summary of findings

- The service must ensure the 62-day cancer waiting times target for appointments is achieved. (Regulation 12).

Diana Princess of Wales Hospital

- The service must continue to address the challenges regarding overdue new and follow up appointments and ensure patients receive their appointment in a timely way across outpatient specialties. (Regulation 12).
- The service must ensure the 62-day cancer waiting times target for appointments is achieved. (Regulation 12).

Goole and District Hospital

- The service must continue to address the challenges regarding overdue new and follow up appointments and ensure patients receive their appointment in a timely way across outpatient specialties. (Regulation 12).
- The service must ensure the 62-day cancer waiting times target for appointments is achieved. (Regulation 12).

Action the trust MUST take to improve in diagnostic imaging:

Scunthorpe General Hospital

- The service must continue to address the challenges regarding waiting lists for treatments and delays in reporting results and ensure patients receive their appointment and results in a timely way across all modalities. (Regulation 12)
- The service must ensure the trajectory for clearing the backlog in unreported results is monitored and action taken to reduce the risk of potential and actual harm to patients still within the backlog of unreported and delayed results. (Regulation 12)

Diana Princess of Wales Hospital

- The service must continue to address the challenges regarding waiting lists for treatments and delays in reporting results and ensure patients receive their appointment and results in a timely way across all modalities. (Regulation 12)
- The service must ensure the trajectory for clearing the backlog in unreported results is monitored and action taken to reduce the risk of potential and actual harm to patients still within the backlog of unreported and delayed results. (Regulation 12)

Goole and District Hospital

- The service must continue to address the challenges regarding waiting lists for treatments and delays in reporting results and ensure patients receive their appointment and results in a timely way across all modalities. (Regulation 12)
- The service must ensure the trajectory for clearing the backlog in unreported results is monitored and action taken to reduce the risk of potential and actual harm to patients still within the backlog of unreported and delayed results. (Regulation 12)

Action the trust MUST take to improve in Community health services for adults:

- The service must ensure that patients receive timely assessment and treatment and put measures in place to address the long waits in the continence service (Regulation 12).

Action the trust MUST take to improve in Community health services for end of life care:

- The trust must ensure that mandatory training compliance rates are in line with trust targets. (Regulation 12).

Summary of findings

- The trust must ensure robust oversight and management of incidents and ensure incidents are shared across the speciality. (Regulation 12).
- The trust must ensure clinical care and treatment are delivered in accordance with national guidance and best practice. (Regulation 17).
- The trust must ensure that robust systems are in place to monitor the effectiveness of care and treatment delivered to achieve good outcomes for patients. (Regulation 17).
- The trust must ensure staff are competent for their role and receive appropriate supervision and appraisal. (Regulation 18).
- The trust must ensure that there are sufficient staff with the right qualifications, skills and training to keep people safe from harm. (Regulation 18).
- The trust must ensure that all complaints are managed in accordance with trust policy. (Regulation 16).
- The trust must ensure robust governance processes are in place to lead, manage, risk assess and sustain effective services. (Regulation 17).

Action the trust SHOULD take to improve:

Action a trust SHOULD take is to comply with a minor breach that did not justify regulatory action, to prevent it failing to comply with legal requirements in future, or to improve services.

Action the trust SHOULD take to improve in urgent and emergency services:

Scunthorpe General Hospital

- The service should ensure patients are given pain relief medication appropriately.
- Action the trust SHOULD take to improve in medical care:
- Scunthorpe General Hospital
- The service should review the non-invasive ventilation (NIV) policy to reflect the correct number of patients receiving level two care at any one time on ward 22 at SGH.
- The service should continue to monitor the average length of stay for elective and non-elective patients to improve performance standards measured against the England average.
- The service should continue to monitor readmission rates for elective admissions to improve performance compared to the England average.
- The service should ensure that version-controlled documents are reviewed in line with trust policy and national guidance.
- The service should ensure medical staffing cover out of hours is sufficient to support continuing professional development of junior doctors.

Diana Princess of Wales Hospital

- The service should ensure medical staffing cover out of hours is enough to maintain patient safety and support continuing professional development of junior doctors.
- The service should ensure that version-controlled documents are reviewed in line with trust policy and national guidance.
- The service should improve data submission to, and compliance with, local audits.

Summary of findings

- The service should continue to monitor the average length of stay for elective and non-elective patients to improve performance standards measured against the England average.
- The service should ensure completion of the vision and strategy for the medical division.

Goole and District Hospital

- The service should ensure that the leadership team can demonstrate how they use the data collected at ward level to drive forward improvements in patient outcomes.

Action the trust SHOULD take to improve in surgery:

Scunthorpe General Hospital

- The service should ensure that there are sufficient qualified, competent, skilled and experienced staff to meet the needs of patients using the service.
- The service should improve systems for recording venous thromboembolism (VTE) assessments.
- The service should continue to ensure that effective processes are in place to enable improvement on the number of fractured neck of femur patients who have surgery within 48 hours.
- The service should continue to improve performance in all national audits and related action plans to improve performance and patient outcomes.
- The service should improve friends and family test response rates and use the outcomes to actively make improvements to patient experience.
- The service should ensure that all premises and equipment is properly maintained and suitable for the purpose in which they are being used.

Diana Princess of Wales Hospital

- The service should improve systems for recording venous thromboembolism (VTE) assessments.
- The service should ensure that there are sufficient qualified, competent, skilled and experienced staff to meet the needs of patients using the service.
- The service should continue to ensure that effective processes are in place to enable improvement on the number of fractured neck of femur patients who have surgery within 48 hours.
- The service should continue to improve performance in all national audits and related action plans to improve performance and patient outcomes.
- The service should improve friends and family test response rates and use the outcomes to actively make improvements to patient experience.
- The service should ensure that all premises and equipment is properly maintained and suitable for the purpose in which they are being used.

Goole and District Hospital

- The service should ensure that records used in theatres for checking of equipment are completed fully and accurately.
- The service should ensure that in theatre recovery a NEWS score is calculated prior to handover of the patient to ward staff.
- The service should ensure that when re-consenting the patient on the day of surgery, the space provided on the consent form to confirm that the patient was re-consented has been completed by the healthcare team.

Summary of findings

Action the trust SHOULD take to improve in critical care:

Scunthorpe General Hospital

- The service should make improvements to the management of infection control including hand hygiene processes.
- Diana Princess of Wales Hospital
- The service should ensure that complaint timeframes are in line with the trusts complaints policy of 60 working days.
- The service should make improvements to the management of infection control including hand hygiene processes.

Action the trust SHOULD take to improve in maternity:

Scunthorpe General Hospital

- The service should ensure the service conducts a child abduction drill.
- The service should review and improve compliance for offering an appointment within 2 weeks of referral for women presenting at over 12 weeks of pregnancy.
- The service should improve maternity record keeping audit assurance and produce a robust action plan to improve performance.
- The service should carefully monitor and actively seek to reduce the total stillbirth rate adjusted to exclude lethal abnormalities, and the stillbirth at term with low birth weight rate.
- The service should implement additional services to reduce the proportion of women smoking at time of book and delivery, in line with trust targets and regional averages.
- The service should ensure risks associated with delayed access to an emergency (second) theatre are closely monitored and minimised.
- The service should monitor and improve WHO safer surgery documentation checklist compliance.
- The service should establish and maintain stable leadership of the service.
- The service should develop a vision for the maternity service and a strategy to turn it into action.

Diana Princess of Wales Hospital

- The service should consider implementing a baby-tagging alarm system, or similar, at the service.
- The service should carefully monitor and actively seek to reduce the total stillbirth rate adjusted to exclude lethal abnormalities, and the stillbirth at term with low birth weight rate.
- The service should implement additional services to reduce the proportion of women smoking at time of book and delivery, in line with trust targets and regional averages.
- The service should establish and maintain stable leadership of the service.
- The service should develop a vision for the maternity service and a strategy to turn it into action.

Goole and District Hospital

- The service should explore the provision of flu vaccination availability in midwifery antenatal clinics at the site.
- The service should assess the sustainability of the midwife-led birth centre at the site, given the very low number of women who have chosen to utilise the facility in the last three years.

Summary of findings

- The service should carefully monitor and actively seek to reduce the total stillbirth rate adjusted to exclude lethal abnormalities, and the stillbirth at term with low birth weight rate.
- The service should implement additional services to reduce the proportion of women smoking at time of book and delivery, in line with trust targets and regional averages.
- The service should establish and maintain stable leadership of the service.
- The service should develop a vision for the maternity service and a strategy to turn it into action.

Action the trust SHOULD take to improve in services for children and young people:

Scunthorpe General Hospital

- The service should continue to develop a clear strategy to turn the vision for the paediatric service into action.
- The service should ensure it can demonstrate assurance that the accessible information standard is met.
- The service should ensure actions identified in local audits for sepsis, hand hygiene and paediatric early warning scores (PEWS) are implemented, embedded and monitored, to provide robust assurance.
- The service should ensure collected safety information is displayed publicly for children, young people, their families and visitors.
- The service should ensure they continue to improve mandatory training compliance.
- The service should ensure all staff are aware of the abduction policy on the intranet and that it is tested.

Diana Princess of Wales Hospital

- The trust should ensure that they are meeting the Accessible Information Standards concerning the communication needs of parents/carers.
- The trust should ensure the abduction policy is tested and exit from the children's ward and paediatric assessment unit is appropriate.
- The trust should ensure that regular checks of resuscitation equipment are completed.
- The trust should ensure that medical staff are completing records accurately, in line with guidance.
- The trust should continue to develop a clear strategy to turn the vision for paediatric services in to action.
- The trust should ensure that actions identified in local audits for sepsis and paediatric early warning scores are implemented and monitored to provide robust assurance.
- The trust should ensure mandatory training compliance improves further.

Action the trust SHOULD take to improve in end of life care:

Scunthorpe General Hospital

- The trust should ensure that the mortuary environment including the approach is considerate of those individuals visiting the area.
- The trust should ensure that version-controlled documents are reviewed in line with trust policy and national guidance.
- The trust should ensure that comprehensive seven-day services are developed in line with national guidance.
- The trust should develop a local strategy and further develop its services for patients with mental health needs.

Summary of findings

- The trust should further develop systems and processes for obtaining feedback from families and carers using the services.

Diana Princess of Wales Hospital

- The trust should ensure that the mortuary environment including the approach is considerate of those individuals visiting the area.
- The trust should ensure that version-controlled documents are reviewed in line with trust policy and national guidance
- The trust should ensure seven-day services are developed in line with national guidance.
- The trust should further develop systems and processes for obtaining feedback from families and carers using the services.

Action the trust SHOULD take to improve in outpatients:

Scunthorpe General Hospital

- The service should ensure records, in outpatient clinics are completed in line with staff's registering bodies.
- The service should continue to clinically validate (Clinically prioritise) waiting lists across outpatient specialties to ensure patients are risk assessed when waiting past their appointment date.
- The service should continue to address the challenges regarding referral to treatment indicators for outpatients.
- The service should consider ways to improve learning from incidents across outpatients.

Diana Princess of Wales Hospital

- The service should ensure records, in outpatient clinics are completed in line with staff's registering bodies.
- The service should continue to clinically validate (Clinically prioritise) waiting lists across outpatient specialties to ensure patients are risk assessed when waiting past their appointment date.
- The service should continue to address the challenges regarding referral to treatment indicators for outpatients.
- The service should consider ways to improve learning from incidents across outpatients.

Goole and District Hospital

- The service should ensure records, in outpatient clinics are completed in line with staff's registering bodies.
- The service should continue to clinically validate (Clinically prioritise) waiting lists across outpatient specialties to ensure patients are risk assessed when waiting past their appointment date.
- The service should continue to address the challenges regarding referral to treatment indicators for outpatients.

Action the trust SHOULD take to improve in diagnostic imaging:

Scunthorpe General Hospital

- The service should ensure the draft divisional strategy is finalised.
- The service should ensure initiatives to address trust wide shortages of radiologists continue to develop including the development of radiographers' capacity to report on results.
- The service should ensure patient records meet standards detailed in trust policies and national body recommendations.

Summary of findings

- The service should ensure complaints are investigated and closed in line with timescales outlined within the trust complaints policy.

Diana Princess of Wales Hospital

- The service should ensure the draft divisional strategy is finalised.
- The service should ensure initiatives to address trust wide shortages of radiologists continue to develop including the development of radiographers' capacity to report on results.
- The service should ensure patient records meet standards detailed in trust policies and national body recommendations.
- The service should ensure complaints are investigated and closed in line with timescales outlined within the trust complaints policy.

Goole and District Hospital

- The service should ensure the draft divisional strategy is finalised.
- The service should ensure initiatives to address trust wide shortages of radiologists continue to develop, including the development of radiographers' capacity to report on results.
- The service should ensure complaints are investigated and closed in line with timescales outlined within the trust complaints policy.

Action the trust SHOULD take to improve in Community health services for adults:

- The service should ensure that therapy staff in the integrated care networks work closely with other members of the team such as community nursing staff and are included in joint team meetings so that information is shared across all staff to allow more integrated working.
- The service should ensure that there are sufficient qualified, competent, skilled and experienced staff to meet the needs of people using the services.
- The service should ensure there are enough laptops available for staff working in the community to allow for effective mobile working.
- The service should ensure staff in the unscheduled care team have access to the equipment they need for clinical assessment of patients including the replacement of tympanic thermometers which do not work in the cold weather.
- The service should develop a standard operating procedure for staff to follow when they are not able to access patients records on the electronic system due to poor connectivity.
- The service should ensure that all patient group directions are approved, signed and dated by the appropriate person/s in the organisation.
- The service should ensure that staff utilise translation services appropriately and do not reply on patients' relatives to translate on the patient's behalf.
- The service should explore and implement other methods of engaging with patients and use the information to develop and improve services.

Action the trust SHOULD take to improve in Community health services for dental:

- The service should take action to ensure that post-operative blood pressure readings are recorded in the dental care records for patients undergoing intravenous sedation.

Summary of findings

- The service should take action to ensure staff report significant events and incidents appropriately.

Action the trust SHOULD take to improve in Community health services for End of Life Care

- The service should ensure that version-controlled documents are reviewed in line with trust policy and national guidance.
- The service should ensure that safeguarding and mental capacity act training is completed in line with trust targets by all end of life staff.
- The service should provide access to written information in community languages for patients and their families.
- The service should ensure that seven-day services are developed in accordance with national guidance.

Is this organisation well-led?

Our comprehensive inspections of NHS trusts have shown a strong link between the quality of overall management of a trust and the quality of its services. For that reason, we look at the quality of leadership at every level. We also look at how well a trust manages the governance of its services – in other words, how well leaders continually improve the quality of services and safeguard high standards of care by creating an environment for excellence in clinical care to flourish.

Our rating of well-led at the trust improved. We rated well-led as requires improvement because:

- Although permanent appointments had been made to key roles, strengthening the leadership at board level, there had been ongoing instability and change occurring within the executive team since our previous inspection. This continued to impact on the trust's ability to drive and sustain the improvements in a timely way. This leadership needs to move at pace to deliver improvements at core service level within the trust. Intensive external support will be required to support the trust to deliver the pace of change and improvement that is needed. However, some staff spoke positively about the visibility of the executive team. Leaders understood issues the service faced.
- Although the service had a vision for what it wanted to achieve and a strategy to turn it into action, this strategy was high level with a lack of supporting and enabling strategies. The vision and strategy were focused on sustainability of services, although there were some financial challenges associated with this.
- Staff felt more respected, supported and valued than during previous inspections. The trust was focused on the needs of staff and patients receiving care. The trust promoted equality and diversity in daily work and provided opportunities for career development. The trust was developing a more open culture where patients, their families and staff could raise concerns without fear but there was more work needed to ensure this became fully embedded.
- More effective governance processes had just been implemented and were evolving, throughout the trust and with partner organisations. Most staff were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.
- The systems to manage of risk, issues and performance had improved. Some services identified and escalated relevant risks. However, the identification of issues and actions to reduce the impact of risks were still not embedded and some risks had not been managed in a timely manner.
- We found that whilst systems and processes had improved and had been implemented the trust were still finding significant quality and patient safety concerns. We remained concerned about the trusts pace of improvement across the services we inspected and the deterioration in some areas. During this inspection we found a number of key questions and core service level ratings had deteriorated and a smaller number had improved since our previous comprehensive inspection in 2018.

Summary of findings

- The trust had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.
- The trust did not always collect reliable data, analyse and use it to make improvements. The records management system within the trust was currently a hybrid system of electronic and paper, this meant that staff could not, at times, find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.
- Leaders and staff were more actively and openly engaging with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.
- Although all staff were committed to continually learning and improving services, quality improvement was in the early stage of implementation and not yet embedded in the organisation. Complaints responses were not met in line with trust policy. There were missed opportunities of learning from death reviews and sharing of this learning was fragmented. Leaders encouraged innovation and participation in research, however there were limited examples of this. Incidents were reported and investigated appropriately, including involving patients and carers.

Ratings tables

Key to tables					
Ratings	Not rated	Inadequate	Requires improvement	Good	Outstanding
Rating change since last inspection	Same	Up one rating	Up two ratings	Down one rating	Down two ratings
Symbol *	→←	↑	↑↑	↓	↓↓
Month Year = Date last rating published					

* Where there is no symbol showing how a rating has changed, it means either that:

- we have not inspected this aspect of the service before or
- we have not inspected it this time or
- changes to how we inspect make comparisons with a previous inspection unreliable.

Ratings for the whole trust

Safe	Effective	Caring	Responsive	Well-led	Overall
Inadequate ↓ Feb 2020	Requires improvement →← Feb 2020	Good →← Feb 2020	Requires improvement →← Feb 2020	Requires improvement ↑ Feb 2020	Requires improvement →← Feb 2020

The rating for well-led is based on our inspection at trust level, taking into account what we found in individual services. Ratings for other key questions are from combining ratings for services and using our professional judgement.

Rating for acute services/acute trust

	Safe	Effective	Caring	Responsive	Well-led	Overall
Diana Princess of Wales Hospital	Inadequate ↓ Feb 2020	Requires improvement ↔ Feb 2020	Good ↔ Feb 2020	Requires improvement ↔ Feb 2020	Requires improvement ↔ Feb 2020	Requires improvement ↔ Feb 2020
Scunthorpe General Hospital	Inadequate ↓ Feb 2020	Requires improvement ↔ Feb 2020	Good ↔ Feb 2020	Requires improvement ↔ Feb 2020	Requires improvement ↔ Feb 2020	Requires improvement ↔ Feb 2020
Goole and District Hospital	Inadequate ↓ Feb 2020	Good ↑ Feb 2020	Good ↔ Feb 2020	Inadequate ↓ Feb 2020	Requires improvement ↔ Feb 2020	Requires improvement ↔ Feb 2020
Overall trust	Inadequate ↓ Feb 2020	Requires improvement ↔ Feb 2020	Good ↔ Feb 2020	Requires improvement ↔ Feb 2020	Requires improvement ↑ Feb 2020	Requires improvement ↔ Feb 2020

Ratings for the trust are from combining ratings for hospitals. Our decisions on overall ratings take into account the relative size of services. We use our professional judgement to reach fair and balanced ratings.

Ratings for a combined trust

	Safe	Effective	Caring	Responsive	Well-led	Overall
Acute	Inadequate ↓ Feb 2020	Requires improvement ↔ Feb 2020	Good ↔ Feb 2020	Requires improvement ↔ Feb 2020	Requires improvement ↔ Feb 2020	Requires improvement ↔ Feb 2020
Community	Requires improvement ↔ Feb 2020	Requires improvement ↓ Feb 2020	Good ↔ Feb 2020	Requires improvement ↔ Feb 2020	Requires improvement ↔ Feb 2020	Requires improvement ↔ Feb 2020
Overall trust	Inadequate ↓ Feb 2020	Requires improvement ↔ Feb 2020	Good ↔ Feb 2020	Requires improvement ↔ Feb 2020	Requires improvement ↑ Feb 2020	Requires improvement ↔ Feb 2020

The rating for the well-led key question is based on our inspection at trust level, taking into account what we found in individual services. Ratings for other key questions take into account the ratings for different types of service. Our decisions on overall ratings take into account the relative size of services. We use our professional judgement to reach fair and balanced ratings.

Ratings for Diana Princess of Wales Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Inadequate ↓ Feb 2020	Requires improvement ↔ Feb 2020	Good ↔ Feb 2020	Requires improvement ↓ Feb 2020	Requires improvement ↓ Feb 2020	Requires improvement ↔ Feb 2020
Medical care (including older people's care)	Requires improvement ↔ Feb 2020	Good ↔ Feb 2020	Good ↔ Feb 2020	Requires improvement ↔ Feb 2020	Requires improvement ↔ Feb 2020	Requires improvement ↔ Feb 2020
Surgery	Requires improvement ↔ Feb 2020	Requires improvement ↔ Feb 2020	Good ↔ Feb 2020	Requires improvement ↔ Feb 2020	Requires improvement ↑ Feb 2020	Requires improvement ↔ Feb 2020
Critical care	Requires improvement ↔ Feb 2020	Requires improvement ↔ Feb 2020	Good ↔ Feb 2020	Requires improvement ↓ Feb 2020	Requires improvement ↔ Feb 2020	Requires improvement ↔ Feb 2020
Maternity	Requires improvement ↔ Feb 2020	Good ↔ Feb 2020	Good ↔ Feb 2020	Requires improvement ↓ Feb 2020	Requires improvement ↓ Feb 2020	Requires improvement ↓ Feb 2020
Services for children and young people	Requires improvement ↔ Feb 2020	Good ↔ Feb 2020	Good ↔ Feb 2020	Good ↔ Feb 2020	Requires improvement ↓ Feb 2020	Requires improvement ↓ Feb 2020
End of life care	Requires improvement ↔ Feb 2020	Inadequate ↓ Feb 2020	Requires improvement ↓ Feb 2020	Requires improvement ↔ Feb 2020	Inadequate ↓ Feb 2020	Inadequate ↓ Feb 2020
Outpatients	Inadequate ↓ Feb 2020	N/A	Good ↔ Feb 2020	Inadequate ↔ Feb 2020	Requires improvement ↑ Feb 2020	Inadequate ↔ Feb 2020
Diagnostic imaging	Inadequate ↓ Feb 2020	N/A	Good ↔ Feb 2020	Inadequate ↓ Feb 2020	Requires improvement ↔ Feb 2020	Inadequate ↓ Feb 2020
Overall*	Inadequate ↓ Feb 2020	Requires improvement ↔ Feb 2020	Good ↔ Feb 2020	Requires improvement ↔ Feb 2020	Requires improvement ↔ Feb 2020	Requires improvement ↔ Feb 2020

*Overall ratings for this hospital are from combining ratings for services. Our decisions on overall ratings take into account the relative size of services. We use our professional judgement to reach fair and balanced ratings.

Ratings for Scunthorpe General Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Inadequate ↓ Feb 2020	Requires improvement ↔↔ Feb 2020	Good ↔↔ Feb 2020	Requires improvement ↓ Feb 2020	Requires improvement ↔↔ Feb 2020	Requires improvement ↔↔ Feb 2020
Medical care (including older people's care)	Requires improvement ↔↔ Feb 2020	Good ↔↔ Feb 2020	Good ↔↔ Feb 2020	Requires improvement ↔↔ Feb 2020	Requires improvement ↔↔ Feb 2020	Requires improvement ↔↔ Feb 2020
Surgery	Requires improvement ↔↔ Feb 2020	Requires improvement ↔↔ Feb 2020	Good ↔↔ Feb 2020	Requires improvement ↔↔ Feb 2020	Requires improvement ↑ Feb 2020	Requires improvement ↔↔ Feb 2020
Critical care	Requires improvement ↔↔ Feb 2020	Good ↑ Feb 2020	Good ↔↔ Feb 2020	Good ↔↔ Feb 2020	Good ↔↔ Feb 2020	Good ↑ Feb 2020
Maternity	Requires improvement ↔↔ Feb 2020	Good ↔↔ Feb 2020	Good ↔↔ Feb 2020	Requires improvement ↓ Feb 2020	Requires improvement ↓ Feb 2020	Requires improvement ↓ Feb 2020
Services for children and young people	Requires improvement ↔↔ Feb 2020	Good ↔↔ Feb 2020	Good ↔↔ Feb 2020	Good ↔↔ Feb 2020	Requires improvement ↓ Feb 2020	Requires improvement ↓ Feb 2020
End of life care	Requires improvement ↔↔ Feb 2020	Inadequate ↓ Feb 2020	Good ↔↔ Feb 2020	Requires improvement ↔↔ Feb 2020	Inadequate ↓ Feb 2020	Inadequate ↓ Feb 2020
Outpatients	Inadequate ↓ Feb 2020	N/A	Good ↔↔ Feb 2020	Inadequate ↔↔ Feb 2020	Requires improvement ↑ Feb 2020	Inadequate ↔↔ Feb 2020
Diagnostic imaging	Inadequate ↓ Feb 2020	N/A	Good ↔↔ Feb 2020	Inadequate ↓ Feb 2020	Requires improvement ↔↔ Feb 2020	Inadequate ↓ Feb 2020
Overall*	Inadequate ↓ Feb 2020	Requires improvement ↔↔ Feb 2020	Good ↔↔ Feb 2020	Requires improvement ↔↔ Feb 2020	Requires improvement ↔↔ Feb 2020	Requires improvement ↔↔ Feb 2020

*Overall ratings for this hospital are from combining ratings for services. Our decisions on overall ratings take into account the relative size of services. We use our professional judgement to reach fair and balanced ratings.

Ratings for Goole and District Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Medical care (including older people's care)	Good ↑ Feb 2020	Good ↑ Feb 2020	Good ↔ Feb 2020	Good ↔ Feb 2020	Good ↑ Feb 2020	Good ↑ Feb 2020
Surgery	Good ↔ Feb 2020	Good ↔ Feb 2020	Good ↔ Feb 2020	Good ↔ Feb 2020	Good ↔ Feb 2020	Good ↔ Feb 2020
Maternity	Good ↔ Feb 2020	Good ↔ Feb 2020	Good ↔ Feb 2020	Good ↔ Feb 2020	Requires improvement ↓ Feb 2020	Good ↔ Feb 2020
Outpatients	Inadequate ↓ Feb 2020	N/A	Good ↔ Feb 2020	Inadequate ↔ Feb 2020	Requires improvement ↑ Feb 2020	Inadequate ↔ Feb 2020
Diagnostic imaging	Inadequate ↓↓ Feb 2020		Good Feb 2020	Inadequate ↓ Feb 2020	Requires improvement ↓ Feb 2020	Inadequate ↓↓ Feb 2020
Overall*	Inadequate ↓ Feb 2020	Good ↑ Feb 2020	Good ↔ Feb 2020	Inadequate ↓ Feb 2020	Requires improvement ↔ Feb 2020	Requires improvement ↔ Feb 2020

*Overall ratings for this hospital are from combining ratings for services. Our decisions on overall ratings take into account the relative size of services. We use our professional judgement to reach fair and balanced ratings.

Ratings for community health services

	Safe	Effective	Caring	Responsive	Well-led	Overall
Community health services for adults	Good ↑ Feb 2020	Good ↔ Feb 2020	Good ↔ Feb 2020	Requires improvement ↔ Feb 2020	Good ↑ Feb 2020	Good ↑ Feb 2020
Community end of life care	Requires improvement ↓ Feb 2020	Requires improvement ↓ Feb 2020	Good ↔ Feb 2020	Requires improvement ↓ Feb 2020	Requires improvement ↓ Feb 2020	Requires improvement ↓ Feb 2020
Community dental services	Good ↑ Feb 2020	Good ↔ Feb 2020	Good ↔ Feb 2020	Good ↔ Feb 2020	Good ↑ Feb 2020	Good ↑ Feb 2020
Overall*	Requires improvement ↔ Feb 2020	Requires improvement ↓ Feb 2020	Good ↔ Feb 2020	Requires improvement ↔ Feb 2020	Requires improvement ↔ Feb 2020	Requires improvement ↔ Feb 2020

*Overall ratings for community health services are from combining ratings for services. Our decisions on overall ratings take into account the relative size of services. We use our professional judgement to reach fair and balanced ratings.

Acute health services

Background to acute health services

Northern Lincolnshire and Goole NHS Foundation Trust was established as a combined hospital trust on 1 April 2001 and achieved foundation status on 1 May 2007. It was formed by the merger of North East Lincolnshire NHS Trust and Scunthorpe and Goole Hospitals NHS Trust and operates all NHS hospitals in Scunthorpe, Grimsby and Goole. In April 2011 the trust became a combined hospital and community services trust (for North Lincolnshire).

The trust provides a range of hospital-based and community services to a population of more than 400,000 people across North and North East Lincolnshire and East Riding of Yorkshire.

The trust has approximately 850 inpatient and critical care beds across 44 wards, 120,000 inpatient episodes, and saw over 360,000 outpatient appointments. The trust employs around 6,500 members of staff.

The trust operates from three hospital sites;

- Diana, Princess of Wales Hospital
- Scunthorpe General Hospital
- Goole and District Hospital

The trust provides the following community health services in North Lincolnshire;

- Adults
- Dental
- End of life care

North Lincolnshire Clinical Commissioning Group (CCG), North East Lincolnshire CCG and East Riding of Yorkshire CCG commission the majority of the trust's services, based on the needs of their local populations.

Summary of acute services

Requires improvement   

Our rating of the trust stayed the same. We rated it as requires improvement because:

- We rated safe as inadequate. We rated effective, responsive and well led as requires improvement. We rated caring as good.
- Our rating of Diana Prince of Wales Hospital stayed the same. We rated it as requires improvement. Of the nine services we inspected, we rated three as inadequate and we rated six services as requires improvement.
- Our rating of Scunthorpe General Hospital stayed the same. We rated it as requires improvement. Of the nine services we inspected, we rated three as inadequate, five as requires improvement and one as good.

Summary of findings

- Our rating of Goole and District Hospital stayed the same. We rated it as requires improvement. Of the five services we inspected, we rated two as inadequate and three as good. Our decisions on overall ratings take into account the relative size of services. We have used our professional judgement to reach fair and balanced ratings.
- Our rating of the trust's community services stayed the same. We rated community health services as requires improvement. We rated one of the three services as requires improvement and two as good.
- We rated well-led for the trust overall as required improvement.

Goole & District Hospital

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Key facts and figures

Goole and District Hospital (GDH) is one of the three hospital sites for Northern Lincolnshire and Goole NHS Foundation Trust. It is located in Goole and serves the population of East Riding of Yorkshire and North Lincolnshire.

GDH is the trust's smallest hospital. The hospital provides non-acute medical care, elective surgery, outpatients and diagnostic imaging and midwifery led maternity services for children, young people and adults primarily in the North East Lincolnshire area. The neuro rehabilitation centre is at GDH, the centre offers specialist services for individuals following severe brain injury and a range of other neurological conditions.

The CQC has carried out a number of inspections of the trust; the last comprehensive inspection of the acute services was in 8-11 May 2018 with an unannounced focused inspection carried out on 23 May 2018. The report was published in September 2018 and overall the trust was rated as requires improvement with safe, effective and responsive being rated as requires improvement and caring rated as good.

We carried out a comprehensive inspection of urgent and emergency care, medicine, surgery, critical care, maternity, services for children and young people, outpatients and diagnostic imaging from 24 to 27 September 2019. We carried out an unannounced inspection on the 10 October 2019.

The trust services are commissioned by the following Clinical Commissioning Groups (CCG's), who commission the majority of the trust's services, and also local authorities.

- Northern East Lincolnshire CCG.
- North and North East Lincolnshire CCG.
- East Riding of Yorkshire CCG.
- North East Lincolnshire council.

Summary of services at Goole & District Hospital

Requires improvement   

Our rating of services stayed the same. We rated it them as requires improvement because:

- There had been little progress identified in this inspection and in some services a deterioration.
- Within outpatients continued backlogs were identified and within diagnostic imaging there was also an increased backlog of patient awaiting diagnostic image services and the subsequent reporting of x-rays. There were unknown risks due to these backlogs.

Summary of findings

- There had been incidents where patients had come to harm due to delays in receiving appointments in both outpatients and diagnostic imaging. We had significant concerns regarding this and after the inspection, the Care Quality Commission completed a section 31 letter of intent to seek further clarification from the trust.
- In maternity we were not assured leaders had oversight of clear and reliable midwifery and nurse staffing data; and we saw sickness rates were high. Community caseloads exceeded the recommended ratio of 96 to 98 cases per WTE midwife. A high proportion of community clinics had been cancelled in the 12 months prior to inspection.
- The service provided mandatory training in key skills to staff but had not ensured everyone had complete it. Across most services there were continued low levels of mandatory training.
- Investigations of complaints were not managed in a timely way and in line with trust policy.
- Across most services there continued to be a lack of clear strategies at this level.
- Systems to manage performance were not consistently used to improve performance.
- There continued to be changes in the governance structures and processes which had not become embedded and therefore there was limited oversight.
- There was limited evidence of continuous improvement and innovation across most core services.

However:

- Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.
- Overall staff felt respected, supported and valued.
- Most services had an open culture where patients, their families and staff could raise concerns without fear.

Medical care (including older people's care)

Good  

Key facts and figures

At Goole and District Hospital medical care was provided across two wards including a general medicine ward and a neuro-rehabilitation ward. Admissions to each ward were by prior arrangement to ensure the site received patients that were deemed medically stable.

We visited both medical wards. We spoke with five patients, 24 staff (including medical and nursing staff) and reviewed nine records of patients including prescription charts.

Summary of this service

We previously inspected medical care services at this site under this trust and overall rated it as requires improvement with requires improvement in safe, effective and well-led, and good in caring and responsive.

At this inspection we rated the services as good because:

- The service provided mandatory training in key skills to all staff and made sure everyone completed it.
- The service had enough nursing and medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed staffing levels and skill mix and gave bank and agency staff a full induction.
- The service managed patient safety incidents well. Staff recognised incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.
- The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance.
- The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development.
- Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patient's consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.
- The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.
- It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint.
- Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.

Medical care (including older people's care)

- Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.
- Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.

However:

- Compliance rates for mandatory training for medical staff were poor. The 85% target was not met for any of the ten modules. We saw the trust had an action plan to improve compliance. The plan was medical staff would be compliant by November 2019.

Is the service safe?

Good  

We rated safe as good because:

- The service provided mandatory training in key skills to all staff and made sure everyone completed it. Nursing and midwifery staff met the target compliance rate in eight out of the ten mandatory training modules. While medical staff did not meet the target (see below) the trust had systems and processes in place to ensure staff not compliant became compliant as the year progressed.
- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it. Nursing staff met the compliance target for training in two out of four safeguarding modules and were at 84% and 79% for the two non-compliant modules. As with mandatory training there was a plan in place to bring staff into compliance.
- The design, maintenance and use of facilities, premises and equipment kept people safe. Staff managed clinical waste well. At the last inspection we said the trust must ensure timely repair and maintenance of facilities. While staff spoken with did highlight one instance of delays to repair, at this inspection the estates division was reporting 81% on completed jobs.
- Staff completed and updated risk assessments for each patient and removed or minimised risks. Staff identified and quickly acted upon patients at risk of deterioration. At the last inspection we said the trust must ensure robust arrangements were in place to ensure sufficient, effective senior clinical oversight to manage patient risk and take appropriate action to respond to urgent or changing needs. We also said staff carrying the emergency bleep required training. At this inspection we saw a site co-ordinator was in post and bleep holders were trained for their role. During safety huddles, staff identified risk and managed it, and in care records we viewed, they documented this, using nationally recognised tools such as national early warning score (NEWS).
- The service had enough nursing and medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed staffing levels and skill mix and gave bank and agency staff a full induction. Actual staffing levels met planned with use of regular agency staff.

Medical care (including older people's care)

- The service managed patient safety incidents well. Staff recognised incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored. To maintain oversight of key performance measures around patient safety, the service used a range of tools including a safety thermometer, dashboard and ward metrics.

However:

- Compliance rates for mandatory training for medical staff were poor. The 85% target was not met for any of the ten modules. We saw the trust had an action plan to improve compliance. The plan was medical staff would be compliant by November 2019.

Is the service effective?

Good  

We rated effective as good because:

- The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance. At the last inspection we said the trust must implement nursing audits to ensure care and safety standards were being met. At this inspection, while there was no specific clinical audit programme for the Goole site, we found there were audits that looked at patient safety and quality, such as, matron walkarounds, point prevalence audits, and monthly ward governance audits.
- Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. The service made adjustments for patients' religious, cultural and other needs. At the last inspection we said policies must be followed for patients that required specialised feeding and hydration. At this inspection we found nutrition and hydration needs were met for patients with systems in place to monitor food and fluid intake and give support where needed.
- Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients. The service was focussed on rehabilitation and maintained detailed data about each patient so that ward staff could track improvement towards goals and report to commissioners, say for additional funding.
- The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development. Staff were regularly appraised and given opportunities to develop their competencies.
- Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patient's consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health. Staff were aware of when patients needed to take additional action such as best interest decisions for patients unable to consent.

However:

- While staff collected data about their patients, it was unclear how the leadership of the relevant division used such data to monitor patient outcomes for the ward or unit, or how the data was used to drive forward any improvements in patient outcomes.

Medical care (including older people's care)

Is the service caring?

Good   

We rated caring as good because:

- Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs. We found that patients received compassionate care from staff which supported their privacy and dignity. For friends and family, the response rate (29%) was better than the England average and recommendation of service rates were over 90%.
- Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs. Most patients we spoke with felt staff were attentive and took time to explain things. Staff had access to chaplaincy services for those with a faith or none. Staff could provide emotional support to patients by using on site psychology services.
- Staff supported patients, families and carers to understand their condition and make decisions about their care and treatment. Staff understood the needs of their patients and involved carers. The service was focused on rehabilitation and patients had access to gyms, day rooms, and on one ward, music therapy and pet therapy. Carers were supported as much as possible by psychologist input and on one ward had access to a kitchen to make drinks and store food.

Is the service responsive?

Good   

We rated responsive as good because:

- The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care. The trust had an operational plan to ensure that its specialities were responsive to the needs of local people by working with commissioners and the public.
- People could access the service when they needed it and received the right care promptly. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were in line with national standards. At the last inspection we said the trust should continue to work to reduce delayed transfers of care. The services had mechanisms in place to manage access and flow using various methods including capturing data on blockages to discharge and designing fixes to any blockages identified.
- It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint. Systems and processes to respond to complaints were effective with only two complaints in the period June 2018 to June 2019.

However:

- Medicine at the site had much higher than average length of stays when compared to the England average. Staff explained this reflected the rehabilitation focus of the site. Staff told us they were meeting commissioners to try and iron out any issues that impacted on access and flow.

Medical care (including older people's care)

Is the service well-led?

Good  

We rated well-led as good because:

- Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles. The divisions for the site had a clear leadership group and senior staff on the wards told us that their leadership team were visible and approachable with opportunities to influence their decisions.
- Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear. At the last inspection we said the trust should review management of the neuro-rehabilitation ward. At this inspection we found new management were in place and reported a much-improved working environment compared to when we last inspected the ward.
- Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service. At the last inspection we asked the trust to review governance arrangements on the neuro-rehabilitation ward. At this inspection we found the governance structure was clear and the local leadership team had plans in place to address risks to the service, with access to information, such as monthly performance reports, to maintain quality.
- Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients. Staff engagement was encouraged with staff surveys, and awards, and patients and the public could feedback through multiple access points.

However:

- The divisions for the Goole site drew upon the trust's vision and strategy, but the trust told us the strategies for the divisions, and in particular what was planned for the Goole site, were still in development.
- There were few examples of learning improvement and innovation.

Areas for improvement

We found areas for improvement in this service. See the Areas for Improvement section above.

Surgery

Good   

Key facts and figures

At Goole and District Hospital (GDH), surgical services provided included general surgery, orthopaedics, ophthalmology, ENT, and urology. The two main theatres at GDH were equipped for major orthopaedic surgery as well as other types of surgery. GDH had two surgical wards, one for day surgery and one for inpatients.

We visited both surgical wards and the two main theatres. We spoke with 13 patients, 16 staff (including medical and nursing staff) and reviewed nine records of patients including prescription charts.

Summary of this service

Our rating of this service stayed the same. We rated it as good because:

- The service provided mandatory training in key skills to all staff and made sure everyone completed it.
- The service had enough nursing and medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed staffing levels and skill mix and gave bank and agency staff a full induction.
- The service managed patient safety incidents well. Staff recognised incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.
- The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance.
- The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development.
- Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patient's consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health. They used agreed personalised measures that limit patients' liberty.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.
- The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.
- It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint.
- Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.

Surgery

- Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.
- Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.

However:

- In theatres some equipment had gaps in its checking regime. While staff explained this was due to theatres being closed on those days, the system for recording this needed to be improved.
- In theatre recovery and prior to transfer back to a ward, staff were not totalling their observation scores to create a national early warning score (NEWS) score, for use by ward staff. This did not appear to comply with the trust's policy. We raised this with staff and were told the issue would be addressed.
- Even though it was clear the trust was going through a further period of change, it was noted that a clearly defined plan, with approved budgets and milestones, to realise the ambition for surgery at the Goole site, was still in progress.
- While the overall governance system functioned, we did find instances in the evidence we reviewed that suggested governance needed tightening up. For example, in theatres at Goole, the new form used in theatres recovery was released for use by staff even though key information was missing from the form. In theatres, NEWS totals were not being calculated for sharing on handover to ward staff. This was arguably in non-compliance with the trust's own policy in this area. In ward areas, for instance, one surgical healthcare team were not completing the space provided on the consent form for re-consenting the patient on the day of the procedure.
- While staff did have access to information to manage their service, various sources of information we reviewed suggested that data management and reliability were an issue for the trust.
- For the surgery division at the Goole site, we saw little evidence of learning, continuous improvement and innovation.

Is the service safe?

Good   

Our rating of safe stayed the same. We rated it as good because:

- The service provided mandatory training in key skills to all staff and made sure everyone completed it. Staff completed mandatory training with seven out of the ten modules meeting the training target. The trust had a plan to improve performance by November 2019.
- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it. Patients were protected from abuse because staff had received training in safeguarding, (staff having met the target for completion of all four safeguarding training modules). The trust had a lead nurse for safeguarding and staff reported good support from the central safeguarding team.
- The service controlled infection risk well. The service used systems to identify and prevent surgical site infections. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean. Ward areas and theatres were visibly clean and for the period August 2018 to August 2019 there were zero cases of healthcare acquired infection.

Surgery

- The design, maintenance and use of facilities, premises and equipment kept people safe. Staff managed clinical waste well. Key equipment, such as resuscitation trolleys, in wards and theatres, were up to date with their checking regimes.
- Staff completed and updated risk assessments for each patient and removed or minimised risks. Staff identified and quickly acted upon patients at risk of deterioration. We saw checks were made on admission to wards for key risks and staff made use of nationally recognised tools to review and assess the safety of their patients.
- The service had enough nursing and medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed staffing levels and skill mix and gave bank and agency staff a full induction. Staffing numbers were reviewed regularly to ensure they were safe despite significant challenges addressed by use of regular agency staff and continued recruitment efforts.
- Staff kept detailed records of patients' care and treatment. Records were clear and up-to-date, stored securely and were easily available to all staff providing care. At the last inspection we said the trust must ensure that all patient records are completed in line with professional and trust standards. While we found some issues with records on the whole they were legible, detailed, signed, and safely stored in locked trolleys when not in use.
- The service used systems and processes to safely prescribe, administer, record and store medicines. We checked the storage of medicines, fluids and gases on the wards we visited. We found that medicines, fluids and gases were stored securely in appropriately locked rooms and for fridges there were checks in place for temperature and stocks seen were in date. For theatres, we found for seven days in September 2019 fridge temperatures had not been checked with no reason given in the log book. This was raised with staff so it could be addressed.
- The service managed patient safety incidents well. Staff recognised incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored. Staff we saw in theatres had embedded the learning from a wrong nerve site block that had occurred in the period June 2018 to May 2019.

However:

- In theatres some equipment had gaps in its checking regime. While staff told us this was due to theatres being closed on those days, the system for recording this needed to be improved.
- In theatre recovery and prior to transfer back to a ward, staff were completing their observations but not calculating a national early warning score (NEWS) for use by ward staff. This did not appear to comply with the trust's policy. We raised this with staff and were told the issue would be addressed.

Is the service effective?

Good   

Our rating of effective stayed the same. We rated it as good because:

- The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance. Policies and pathways were based on guidance from the Royal College of Surgeons and the National Institute for Health and Care Excellence (NICE). World Health Organisation surgical safety checklists (WHO) were completed. Auditing of WHO records showed for the period October 2018 to August 2019, performance of WHO audits at the Goole site was 100%, apart from for four months, but never went below 90%.

Surgery

- Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. The service made adjustments for patients' religious, cultural and other needs. Staff followed national guidelines to make sure patients fasting before surgery were not without food for long periods. We found that the services had systems and processes in place to effectively support staff to meet the nutrition and hydration needs of patients and visitors.
- Staff assessed and monitored patients regularly to see if they were in pain and gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain. We found that the service had systems and processes in place to effectively support staff to meet the pain relief needs of patients.
- Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients. The trust reported that for April 2016 to March 2017 for groin hernia and April 2017 to March 2018 for hip and knee, the outcomes showed the trust were neither positive or negative outliers.
- The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development. At the last inspection we said the trust must ensure that 95% of staff had an up to date appraisal in line with their own target. As at end of August 2019 the trust reported compliance for surgical ward six was 100%, surgical ward seven 80% and theatres 93%.
- Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patient's consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health. We found staff we spoke with knew the importance of gaining consent to treatment and had received training in consent, mental capacity and deprivation of liberty safeguards.

However:

- In one surgical healthcare team on one day on one list we saw that staff were not recording the re-consenting of patients on the day of surgery in accordance with the consent forms provided for that purpose. Staff told us they would raise our concerns with the healthcare team concerned to avoid the issue re-occurring. On another day, across different surgical healthcare teams, on different lists, we found this was not an issue.

Is the service caring?

Good   

Our rating of caring stayed the same. We rated it as good because:

- Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs. Patients' described the care they received in positive terms and friends and family recommendation rates were over 90% although trust wide the response rates were below the England average.
- Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs. The trust had a multi-faith chaplaincy service and bereavement service and patients confirmed staff provided emotional support. The bereavement service scored positively in recent audits.
- Staff supported patients, families and carers to understand their condition and make decisions about their care and treatment. Patients we spoke with understood about their care, and the trust told us about initiatives they had taken, for instance, to involve and understand patients by allowing carers to attend the anaesthetic room for patients with learning disabilities.

Surgery

Is the service responsive?

Good  → ←

Our rating of responsive stayed the same. We rated it as good because:

- The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care. The direction of travel at a priority level relevant to the Goole site was to make more use of the Goole site for surgery.
- The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers. We saw that staff cared for patients as individuals and strived to meet their individual needs.
- People could access the service when they needed it and received the right care promptly. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were in line with national standards. From March 2018 to February 2019, the average length of stay for patients having elective surgery at Goole and District Hospital was 2.7 days. The average for England was 3.8 days. From June 2018 to May 2019, the trust's referral to treatment time (RTT) for admitted pathways for surgery was about the same as the England average. In the latest period, May 2019, performance was slightly higher (67.1%), when compared to the England average (64.7%).
- It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint. The services had a system in place to encourage complaints and compliments with a view to improving services for patients.

However:

- While the number of complaints at the Goole site for surgery during the period June 2018 to June 2019 were low (four), we noted two of those complaints took 163 and 117 working days to close, against a target of 60 working days.

Is the service well-led?

Good  → ←

Our rating of well-led stayed the same. We rated it as good because:

- Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles. The surgical division had a management structure in place with clear lines of responsibility and accountability; senior staff were motivated and enthusiastic about their roles and had plans which, subject to budgets, were designed to improve patient care.
- Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear. We observed that the services we visited had staff that were proud to provide patient focussed care to patients.

Surgery

- Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service. All ward sisters said they were supported well by the senior management team and were particularly supportive of the site co-ordinator and the difference they had made to governance at site level.
- Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care. At the last inspection we said the trust must ensure that service risks are identified, reviewed, updated and senior management teams had oversight. At this inspection we found the systems for identifying, reviewing and updating risks and providing oversight worked.
- The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required. From speaking with staff and reviewing information supplied in electronic format, it was clear that staff at all levels could access information in a digital format which could be used to help improve the service.
- Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients. At the last inspection we said the trust should take steps to improve its staff and public engagement activities. Staff and the trust gave examples of how they engaged with the public and staff with a view to ensuring their views were used to help shape the service provided to patients.

However:

- Even though it was clear the trust was going through a further period of change, it was noted that a clearly defined plan, with approved budgets and milestones, to realise the ambition for surgery at the Goole site, was still in progress.
- While the overall governance system functioned, we did find instances in the evidence we reviewed that suggested governance needed tightening up. In theatres at Goole, for example, the new form used in theatres recovery was released for use by staff even though key information was missing from the form. Or NEWS totals not being calculated for sharing on handover to ward staff, arguably in non-compliance with the trust's own policy in this area. In ward areas, for instance, one surgical healthcare team not completing the space on the form for re-consenting the patient.
- While staff did have access to information to manage their service, various sources of information we reviewed suggested that data management and reliability were an issue for the trust.
- For the surgery division at the Goole site, we saw little evidence of learning, continuous improvement and innovation.

Areas for improvement

We found areas for improvement in this service. See the Areas for Improvement section above.

Maternity

Good   

Key facts and figures

Northern Lincolnshire and Goole NHS Foundation Trust provides a range of maternity services for women at three acute hospital sites. The trust has 72 acute maternity beds located across six wards; four wards at Diana, Princess of Wales hospital, and two at Scunthorpe General hospital. At Goole and District Hospital, the hospital offers daily antenatal midwife led clinics with a weekly obstetric clinic, there is also a one-bedded birthing suite available on site.

The maternity service at Goole District Hospital is a midwife-led unit and principally serves the East Riding area. There are three local teams of community midwives within the wider Scunthorpe and Goole team. Community midwives work on-call each month, and this can include working in the central delivery suite at Scunthorpe General Hospital.

There is a midwifery-led birthing suite onsite at Goole District Hospital. The birthing suite is in within the grounds of the hospital, with no other inpatient obstetric or neonatal services onsite. The unit therefore supports low risk women who want a birth in a 'home away from home' setting. Those considered high risk are transferred to Scunthorpe General Hospital for delivery.

Community midwives work flexibly across services, offering antenatal and postnatal care in clinics at Goole District Hospital, GP practices, children's centres, and in women's homes.

A weekly obstetric clinic is available for women at Goole District Hospital who meet high risk criteria and need consultant led care closer to home.

From April 2018 to March 2019, there were 34 home births across Scunthorpe and Goole community services, and three deliveries in the midwifery-led birthing unit at Goole and District Hospital.

During our inspection, we visited the maternity unit and spoke with two patients and their companions, and six members of staff. These included the community manager, midwives, health care assistants, and an administrative assistant. We observed care and treatment and looked at three complete patient records. We also interviewed key members of staff, medical staff and the senior management team who were responsible for the leadership and oversight of the service.

Summary of this service

Our rating of this service stayed the same. We rated it as good because:

- The service provided care and treatment based on national guidance and best practice. Staff completed and updated risk assessments for each woman and took action to remove or minimise risks. Staff were competent for their roles.
- Staff understood how to protect women and children from abuse and the service worked well with other agencies to do so.
- The design, maintenance and use of facilities, premises and equipment kept people safe. Staff carried out daily and weekly safety checks of specialist and emergency equipment, and the service controlled infection risk well.
- The service used systems and processes to safely prescribe, administer, record and store medicines.

Maternity

- Staff treated women with compassion and kindness, provided emotional support, respected their privacy and dignity, and took account of their individual needs. Staff supported women to make informed decisions about their care and treatment and followed national guidance to gain patients' consent.
- The service had an open culture where patients, their families and staff could raise concerns without fear. The service treated concerns and complaints seriously, investigated them and shared lessons learned with staff.
- The service provided mandatory training in key skills to all staff; however, they did not make sure all staff completed it. Completion rates for safeguarding adults' training and Mental Capacity training were low among community midwifery staff.

However:

- We were not assured leaders had oversight of clear and reliable midwifery and nurse staffing data; and we saw sickness rates were high. Community caseloads, allowing for some changes in allowances and changes in NICE Guidance since 2009, exceeded the recommended ratio of 96 to 98 cases per WTE midwife. A high proportion of community clinics had been cancelled in the 12 months prior to inspection.
- Leaders and senior staff had the necessary experience and knowledge to lead effectively. However, there had been some instability in the leadership team. Staff expressed concerns about leadership stability and the implementation of new models of care; and described morale within the service had wavered.
- We saw a continued pattern of decline in use of the midwife-led birth suite at the hospital. No decisive action had been taken to ensure the sustainability of the unit, and there was no local vision for the maternity service and a strategy to turn it into action.

Is the service safe?

Good   

Our rating of safe stayed the same. We rated it as good because:

- Staff kept detailed records of women's care and treatment; and completed and updated risk assessments for each woman and took action to remove or minimise risks. Staff identified and quickly acted upon women at risk of deterioration.
- Staff understood how to protect women from abuse and the service worked well with other agencies to do so.
- The service controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.
- The design, maintenance and use of facilities, premises and equipment kept people safe. Staff managed clinical waste well.
- The service used systems and processes to safely prescribe, administer, record and store medicines.

However:

- The service provided mandatory training in key skills to all staff; however, they did not make sure all staff completed it. Completion rates for safeguarding adults' training were low among community midwifery staff.
- The service had not conducted quarterly 'live' (unannounced) emergency skills and drills training, in line with trust policy; and staff confirmed that they had not undertaken a recent (planned or 'live') pool evacuation drill within the last 18 to 24 months.

Maternity

Is the service effective?

Good  → ←

Our rating of effective stayed the same. We rated it as good because:

- The service provided care and treatment based on national guidance and best practice. Managers checked to make sure staff followed guidance. Staff carried out daily and weekly safety checks of specialist and emergency equipment.
- Staff gave women enough food and drink to meet their needs and improve their health monitored women regularly to see if they were in pain; and gave women practical support and advice to lead healthier lives.
- The service made sure staff were competent for their roles. Managers appraised midwifery and support staff work performance and held supervision meetings with them to provide support and development.
- Staff supported women to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. They knew how to support women who lacked capacity to make their own decisions or were experiencing mental ill health.
- Doctors, nurses and other healthcare professionals worked together as a team to benefit women. They supported each other to provide good care. Key services were available seven days a week to support timely care.

However:

- The total stillbirth rate adjusted to exclude lethal abnormalities, and the stillbirth at term with low birth weight rate, were higher than regional averages.
- The proportion of women smoking at time of booking and delivery were higher than trust targets and regional averages.
- Mental Capacity Act training compliance was low and did not meet trust targets.

Is the service caring?

Good  → ←

Our rating of caring stayed the same. We rated it as good because:

- Staff treated women with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.
- Staff provided emotional support to women, families and carers to minimise their distress. They understood patient's personal, cultural and religious needs.
- Staff supported women, families and carers to understand their condition and make decisions about their care and treatment.

Is the service responsive?

Good  → ←

Our rating of responsive stayed the same. We rated it as good because:

Maternity

- The service worked with others in the wider system and local organisations to plan care. Waiting times from referral to booking before 13 weeks were in line with national standards.
- The service was inclusive and took account of women's individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.
- It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with staff.

However:

- People could not always access the service when they needed it and receive the right care promptly; for example, data showed 280 clinics had been cancelled in the community over a 12-month period.

Is the service well-led?

Requires improvement  

Our rating of well-led went down. We rated it as requires improvement because:

- Leaders and senior staff had the necessary experience and knowledge to lead effectively. However, there had been some instability within the team. Staff expressed concerns about leadership stability and the implementation of new models of care; and described morale within the service had wavered.
- We saw a continued pattern of decline in use of the midwife-led birth suite at the hospital; from April 2017 to March 2019, only six women had delivered at the facility. No decisive action had been taken to ensure the sustainability of the unit.
- The service did not have an agreed vision for what it wanted to achieve and the strategy to turn it into action was in draft. In addition, the divisional strategy was in draft form.
- We were not assured leaders always operated effective governance processes; for example, we found the quality of women's and children's divisional meeting minutes varied.
- The service did not always collect and collate reliable data; for example, we were not assured NICE red flag data was valid and reliable, and we observed some inaccuracies in other data we reviewed. We were not assured that the service had oversight of clear and reliable midwifery and nurse staffing data.

However:

- Leaders and teams identified and escalated key risks. Actions to reduce their impact were considered. However, we were not assured that leaders always used systems to manage performance effectively. There were cross-site obstetrics and gynaecology governance meetings, and a lead governance midwife had recently been appointed.
- Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. The service had an open culture where patients, their families and staff could raise concerns without fear.
- Staff felt respected, supported and valued by colleagues and were focused on the needs of patients receiving care.
- Staff could find most key data they needed, in easily accessible formats, to understand performance, make decisions and improvements. However, leaders recognised improvements in data collection, reliability and accessibility were needed. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.

Maternity

Areas for improvement

We found areas for improvement in this service. See the Areas for Improvement section above.

Outpatients

Inadequate ● → ←

Key facts and figures

Outpatient services are provided on all three hospital sites in dedicated outpatient areas. There were a number of out-reach clinics that take place outside of the main hospital sites. The majority of clinics were provided during core hours; however, a small number of evening and weekend clinics took place.

Outpatients and pathology were part of the clinical support services division. Clinical Support Services Division role was to provide nursing staff, administration support for receptions and all of the health records functionality. A range of clinics were provided by outpatients such as surgery outpatients, medicine outpatients, ophthalmology, respiratory, diabetes, urology, neurology and ear, nose and throat.

Waiting lists for each speciality were held by that speciality. The method of delivery was predominantly face to face, however, the trust were beginning to review patients via telephone clinics.

During the inspection we visited the main outpatient department and the ophthalmology department.

Our inspection was announced (staff knew we were coming) to enable us to observe routine activity.

During the inspection we spoke with eight staff, twenty patients and reviewed two records.

Total number of first and follow up attendances compared to England

The trust had 374,436 first and follow up outpatient attendances from March 2018 to February 2019.

(Source: Hospital Episode Statistics - HES Outpatients)

Summary of this service

Our rating of this service stayed the same. We rated it as inadequate because:

- The trust had identified incidents in 2018 and 2019 where patients had come to harm due to delays in receiving appointments in out-patients. We had significant concerns regarding this and requested further information from the trust on what it was doing to limit risk in a section 31 “letter of intent to seek further clarification from the trust”. The trust provided a response to this. CQC continue to have concerns about the risks of harm and potential harm to patients when waiting times remain lengthy. However, we were assured that the trust had put in place oversight mechanisms and processes to limit the risks.
- After the inspection, the trust told us they had revised the inclusion criteria for patients to be added to the clinical harm review in ophthalmology to include any delay that exceeded the speciality/department risk stratification criteria. For example, in September 2019, this new risk stratification criteria had identified 83 patients to be added to the clinical harm review. Of these 83 patients, 37 patients had been seen and assessed for harm and the trust highlighted there was no harm in 24 of these patients, there was low harm in ten patients and one moderate harm and two severe harm. Out of the 83 patients identified, the remaining 46 patients were due to have a clinical harm review in November 2019.
- Whilst the trust had implemented clinical validation to help ensure patients were seen in order of clinical need, there remained significant risk in some waiting lists due to the volume of patients on the waiting list and the service not

Outpatients

meeting the operational standard for patients receiving their first treatment within 62 days of an urgent GP referral for a suspected cancer diagnosis. This was an ongoing concern since our previous inspection. The trust provided information after the inspection stating they were taking steps to address the challenges with cancer performance in accordance with the trust's performance management framework.

- We did not see evidence of safety checklists being used in any areas other than in ophthalmology.
- Although records were now stored securely, which was an improvement since our last inspection, records were not always timed or signed by staff, and staff did not always provide their role or designation. Written notes were not consistently legible. These concerns were ongoing since our previous inspection.
- Although the oversight of waiting lists and backlogs had improved, the July 2019 board papers showed there remained 33,673 overdue outpatient review appointments in May 2019. Overall there had been improvements with the referral to treatment indicators, however there remained specialties which did not always achieve the referral to treatment indicators.
- From June 2018 to May 2019 the trust's referral to treatment time (RTT) for non-admitted pathways has been worse than the England overall performance. The latest figures for May 2019, showed 78.7% of this group of patients were treated within 18 weeks versus the England average of 87.6%.
- From June 2018 to May 2019 the trust's referral to treatment time (RTT) for incomplete pathways has been worse the England overall performance, although there has been an improving trend from January to May 2019. The latest figures for May 2019 showed 77.8% of patients still waiting for treatment had been waiting for less than 18 weeks, versus the England average of 86.4%.
- From June 2018 to June 2019, the trust received 134 complaints in relation to outpatients at the trust (27.6% of total complaints received by the trust). 66 complaints were still open and under investigation or partially upheld with no closed date. Of the 68 complaints that were closed, the trust took an average of 82.2 working days to investigate and close complaints. This was not in line with their complaints policy, which states complaints should be closed within 60 working days.
- From March 2018 to February 2019, the did not attend rate for Diana, Princess of Wales Hospital was higher (worse) than the England average. At the previous inspection, there was no strategy in place and although the trust had developed a strategy and provided the draft strategy for outpatients, this was still a draft version.

However, we also found:

- The service provided mandatory training in key skills to all staff and made sure everyone completed it. Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.
- The service controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean. Staff managed clinical waste well.
- The service had enough nursing and support staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed staffing levels and skill mix and gave bank staff a full induction. The service used systems and processes to safely prescribe, administer, record and store medicines.
- Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care. Staff gave patients practical support and advice to lead healthier lives. Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent.

Outpatients

- Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs. Staff provided emotional support to patients, families and carers to minimise their distress. Patients were given contact details for specialist nurses to contact with any worries or questions.
- Staff supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment. Patients we spoke with gave positive feedback about their care and treatment in outpatients at this hospital.
- The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. Leaders and teams used systems to manage performance.
- There had been improvement in some areas and improved oversight and governance regarding the challenges across outpatient services. The services had implemented procedures to support the work regarding the challenges in outpatients, for example outpatient leaders monitored performance through performance reports and regular meetings.
- The service collected data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Leaders and staff actively and openly engaged with patients.

Is the service safe?

Inadequate ● ↓

Our rating of safe went down. We rated it as inadequate because:

- The trust had identified incidents in 2018 and 2019 where patients had come to harm due to delays in receiving appointments in out-patients. We had significant concerns regarding this and requested further information from the trust on what it was doing to limit risk in a section 31 “letter of intent to seek further clarification from the trust”. The trust provided a response to this. CQC continue to have concerns about the risks of harm and potential harm to patients when waiting times remain lengthy. However, we were assured that the trust had put in place oversight mechanisms and processes to limit the risks.
- Following the inspection, the trust provided more information which showed they had revised the inclusion criteria for patients to be added to the clinical harm review in ophthalmology to include any delay that exceeded the speciality/department risk stratification criteria. For example, in September 2019, this new risk stratification criteria had identified 83 patients to be added to the clinical harm review. Of these 83 patients, 37 patients had been seen and assessed for harm and the trust highlighted there was no harm in 24 of these patients, there was low harm in ten patients and one moderate harm and two severe harm. Out of the 83 patients identified, the remaining 46 patients were due to have a clinical harm review in November 2019.
- Whilst the trust had implemented clinical validation to help ensure patients were seen in order of clinical need, there remained risk in some waiting lists due to the volume of patients on the waiting list and the service not meeting the operational standard for patients receiving their first treatment within 62 days of an urgent GP referral for a suspected cancer diagnosis. This was an ongoing concern since our previous inspection.
- We did not see evidence of safety checklists being used in any areas other than in ophthalmology.
- Although records were now stored securely, which was an improvement since our last inspection, records were not always timed and staff did not always provide their role or designation. Written notes were not consistently legible. These concerns were ongoing since our previous inspection.

Outpatients

However:

- The service provided mandatory training in key skills to all staff and made sure everyone completed it. Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.
- The service controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean. Staff managed clinical waste well.
- The service had enough nursing and support staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed staffing levels and skill mix and gave bank staff a full induction. The service used systems and processes to safely prescribe, administer, record and store medicines.

Is the service effective?

Not sufficient evidence to rate



We do not rate effective in outpatients, however we found:

- The service provided care and treatment based on national guidance and evidence of its effectiveness. Managers checked to make sure staff followed guidance.
- Staff gave patients enough food and drink to meet their needs and improve their health.
- Staff monitored the effectiveness of care and treatment.
- The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development.
- Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.
- Staff gave patients practical support and advice to lead healthier lives.
- Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent.

Is the service caring?

Good



Our rating of caring stayed the same. We rated it as good because:

- Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.
- Staff provided emotional support to patients, families and carers to minimise their distress. Patients were given contact details for specialist nurses to contact with any worries or questions.
- Staff supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment.
- All of the patients we spoke with gave positive feedback about their care and treatment in outpatients at this hospital.

Outpatients

Is the service responsive?

Inadequate ● → ←

Our rating of responsive stayed the same. We rated it as inadequate because:

- Although the oversight of waiting lists and backlogs had improved, the July 2019 board papers showed there remained 33,673 overdue outpatient review appointments in May 2019.
- There remained challenges with the services meeting the 62-day cancer waiting time targets. The trust was performing worse than the 85% operational standard for patients receiving their first treatment within 62 days of an urgent GP referral. This was an issue at the previous inspection. The trust provided further information stating that they were aware of the need to improve and had taken additional actions to address this such as bringing in external clinical expertise to work alongside clinicians to change and improve decision making.
- Overall referral treatment times had improved in some specialities since our May 2018 inspection. The trust also provided some information which showed a reduction in patients waiting more than 40+ weeks from 1503 to 311, however there remained challenges within some specialities.
- From June 2018 to May 2019 the trust's referral to treatment time (RTT) for non-admitted pathways has been worse than the England overall performance. The latest figures for May 2019, showed 78.7% of this group of patients were treated within 18 weeks versus the England average of 87.6%.
- From June 2018 to May 2019 the trust's referral to treatment time (RTT) for incomplete pathways has been worse the England overall performance, although there has been an improving trend from January to May 2019. The latest figures for May 2019 showed 77.8% of patients still waiting for treatment had been waiting for less than 18 weeks, versus the England average of 86.4%.
- From June 2018 to June 2019, the trust received 134 complaints in relation to outpatients at the trust (27.6% of total complaints received by the trust). 66 complaints were still open and under investigation or partially upheld with no closed date. Of the 68 complaints that were closed, the trust took an average of 82.2 working days to investigate and close complaints. This was not in line with their complaints policy, which states complaints should be closed within 60 working days.
- From March 2018 to February 2019, the did not attend rate for Diana, Princess of Wales Hospital was higher (worse) than the England average.

However:

- The service worked with others in the wider system and local organisations to plan care.
- The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services.
- The trust is performing better than the 93% operational standard for people being seen within two weeks of an urgent GP referral.
- The trust is performing better than the 96% operational standard for patients waiting less than 31 days before receiving their first treatment following a diagnosis (decision to treat).

Outpatients

Is the service well-led?

Requires improvement ● ↑

Our rating of well-led improved. We rated it as requires improvement because:

- Although there had been improvements in the governance and oversight of waiting lists and backlogs. There remained challenges with the backlog of overdue patients waiting for appointments, referral to treatment indicators and the 62-day cancer waiting times remained a challenge. The trust provided information after the inspection stating they were taking steps to address the challenges with cancer performance in accordance with the trust's performance management framework.
- There had been incidents of patient harm which related to the delay in treatment across the specialties, for example in ophthalmology outpatients.
- At the previous inspection, there was no strategy in place and although the trust had developed a strategy and provided the draft strategy for outpatients, this was still a draft version.
- There was limited evidence of innovation across the outpatient departments.

However:

- The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. Leaders and teams used systems to manage performance.
- There had been improvement in some areas and improved oversight and governance regarding the challenges across outpatient services. The services had implemented procedures to support the work regarding the challenges in outpatients, for example outpatient leaders monitored performance through performance reports and regular meetings.
- The service collected data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Leaders and staff actively and openly engaged with patients.

Areas for improvement

We found areas for improvement in this service. See the Areas for Improvement section above.

Diagnostic imaging

Inadequate ● ↓

Key facts and figures

Radiology is provided across the three main sites: DPOW site provides X-ray, fluoroscopy, CT, MRI, ultrasound, breast imaging and nuclear medicine services; SGH provides X-ray, fluoroscopy, CT, MRI and ultrasound; and Goole and District Hospital provides X-ray, fluoroscopy, and ultrasound with some mobile CT & MRI provision at this site.

Most services are provided across seven days, the exceptions being breast imaging and nuclear medicine which are five-day services. Emergency services are provided 24/7 for X-ray and CT at the two main sites. There is some community ultrasound provision, in GP surgeries across the region.

Audiology services are provided from all three hospital sites, as well as in many community settings. Physiological measurement investigations are undertaken on the two main hospital sites by a team based at DPOW.

(Source: Routine Provider Information Request (RPIR) – AC1. Context acute)

Summary of this service

Our rating of this service went down. We rated it as inadequate because:

- Patients could not always access the service when they needed it. Waiting and result reporting times were not in line with national standards.
- There had been incidents where patients had come to harm due to delays in reporting results. We had significant concerns regarding this and after the inspection, the Care Quality Commission completed a section 31 letter of intent to seek further clarification from the trust.
- Safety was not a sufficient priority. Although there was measurement and monitoring of safety performance, there was a limited response leading to unacceptable levels of incidents and potential harm.
- There had been a lack of pace to address the backlogs and therefore there were concerns that incidents and near misses were not recognised which had caused harm and put patients at risk of harm or potential harm.
- From May 2018 to April 2019, the percentage of patients waiting more than six weeks to see a clinician (12%) was higher than the England average (3%).
- Substantial, ongoing and frequent staff shortages increased risks to people who used services.
- Although, the trust had systems for identifying risks in place, opportunities to prevent and minimise harm were missed.
- Since our last inspection in 2018, the backlog in unreported results had increased from 5,364 examinations (3,686 patients) to 10,701 examinations (7,045 patients) in July 2019.
- The contract with the external reporting company to address the backlog had been put in place in August 2019. This delay increased the potential risk of harm to patients.
- At the time of inspection, the overall backlog in unreported results across all modalities was 7,942 delays (4,719 patients).
- Following inspection, the initial trajectory for clearing the backlog in unreported results had changed and extended, increasing the risk of potential and actual harm to patients still within the backlog of unreported and delayed results.

Diagnostic imaging

- There were trust wide shortages of radiologists. This impacted on reporting rates across the trust.
- Although there was some resistance from existing radiologists to supporting the long-term development of radiographers' capacity to report on results, the expansion of plain film reporting to chest and abdomen was supported and the Trust had also put in place other initiatives to improve their reporting capacity.
- Local rules were not clear as to which procedures could be requested by individual clinicians.
- Local dosage reference levels (DRLs) were not in place or displayed in all appropriate rooms.
- A finalised divisional strategy was not in place and had been developed to draft stage only.

However:

- The service provided mandatory training in key skills to all staff and made sure everyone completed it.
- The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use equipment.
- Staff we spoke with were aware of their responsibilities in relation to duty of candour.
- The service provided care and treatment based on national guidance and evidence of its effectiveness. Managers checked to make sure staff followed guidance.
- Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.
- In August 2019, 86% of people who completed the Friends and Family Test (FFT) were extremely likely or likely to recommend this service to their family and friends.
- The service planned and provided care in a way that met the needs of local people and the communities served.

Is the service safe?

Inadequate ● ↓

Our rating of safe went down. We rated it as inadequate because:

- At the time of inspection, the overall backlog in unreported results across all modalities was 7,942 delays (4,719 patients).
- Following inspection, the initial trajectory for clearing the backlog in unreported results had changed and extended, increasing the risk of potential and actual harm to patients still within the backlog of unreported and delayed results.
- There had been incidents where patients had come to harm due to delays in reporting results. We had significant concerns regarding this and after the inspection, the Care Quality Commission completed a section 31 letter of intent to seek further clarification from the trust.
- There was insufficient numbers of medical staff.
- Safety was not a sufficient priority. Although there was measurement and monitoring of safety performance, there was a limited response leading to unacceptable levels of serious incidents and potential harm.

Diagnostic imaging

- There had been a lack of pace to address the backlogs and therefore there were concerns that incidents and near misses were not recognised which had caused harm and put patients at risk of harm or potential harm.
- Local rules were not clear as to which procedures could be requested by individual clinicians.
- Local dosage reference levels (DRLs) were not in place or displayed in all appropriate rooms.
- There were trust wide shortages of radiologists. This impacted on reporting rates across the trust.

However, we also found:

- The service provided mandatory training in key skills to all staff and made sure everyone completed it.
- The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use equipment.
- Staff we spoke with were aware of their responsibilities in relation to duty of candour.

Is the service effective?

Not sufficient evidence to rate ●

We do not rate effective in diagnostic imaging, however we found:

- The service provided care and treatment based on national guidance and evidence of its effectiveness. Managers checked to make sure staff followed guidance.
- Staff monitored the effectiveness of care and treatment.
- Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.
- Staff gave patients practical support and advice to lead healthier lives.
- The service made sure staff were competent for their roles.

Is the service caring?

Good ● ➡ ➡

Our rating of caring stayed the same. We rated it as good because:

- Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.
- Staff provided emotional support to patients, families and carers to minimise their distress.
- Staff supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment.
- All patients gave positive feedback about their care and treatment in outpatients at this hospital.
- In August 2019, 86% of people who completed the Friends and Family Test (FFT) were extremely likely or likely to recommend this service to their family and friends.

Diagnostic imaging

Is the service responsive?

Inadequate  

Our rating of responsive went down. We rated it as inadequate because:

- The service did not provide care in a way that met the needs of local people and the communities served. However the department was accessible.
- Patients could not always access the service when they needed it. Waiting and result reporting times were not in line with national standards.
- From May 2018 to April 2019, the percentage of patients waiting more than six weeks to see a clinician (12%) was higher than the England average (3%).
- Substantial, ongoing and frequent staff shortages increased risks to people who used services.
- Since our last inspection in 2018, the backlog in unreported results had increased from 5364 examinations (3,686 patients) to 10,701 examinations (7,045 patients) in July 2019.
- The contract with the external reporting company to address the backlog had been put in place in August 2019. This delay increased the potential risk of harm to patients.
- Following inspection, the initial trajectory for clearing the backlog in unreported results had changed and extended, increasing the risk of potential and actual harm to patients still within the backlog of unreported and delayed results.

However:

- The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services.
- The trust were taking actions to address the backlogs and had reduced these by 47% by November 2019.

Is the service well-led?

Requires improvement   

Our rating of well-led stayed the same. We rated it as requires improvement because:

- At the time of inspection, the overall backlog was 7,942 delays in reporting results affecting 4,719 patients.
- Although there was a governance structure in place monitoring waiting lists for treatments and delays in reporting results, the delay in finalising the contract with the external reporting company had increased the potential risk of harm to patients.
- Although we saw evidence that the trust was actively assessing and monitoring risks to patients, we were not assured that these were managed in a timely way to prevent or minimise harm.
- Although, the trust had systems for identifying risks in place, opportunities to prevent and minimise harm were missed.
- At the previous inspection, a strategy was not in place and although the division had developed a strategy, this had not been finalised.

Diagnostic imaging

- Although there was some resistance from existing radiologists to supporting the long-term development of radiographers' capacity to report on results, the expansion of plain film reporting to chest and abdomen was supported and the Trust had also put in place other initiatives to improve their reporting capacity.

However:

- Leaders and staff engaged with patients and most staff felt respected, supported and valued.

Areas for improvement

We found areas for improvement in this service. See the Areas for Improvement section above.

Diana Princess of Wales Hospital

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www.nlg.nhs.uk

Key facts and figures

Diana Princess of Wales Hospital (DPoW) is one of the three hospital sites for Northern Lincolnshire and Goole NHS Foundation Trust. It is located in Grimsby and provides acute hospital services to the North East Lincolnshire area.

DPoW is the trust's largest hospital. It offers a range of inpatient and outpatient services including urgent and emergency care, medical care, surgery, critical care, maternity, end of life and outpatients and diagnostic services for children, young people and adults primarily in the North East Lincolnshire area.

The CQC has carried out a number of inspections of the trust; the last comprehensive inspection of the acute services was in 8-11 May 2018 with an unannounced focused inspection carried out on 23 May 2018. The report was published in September 2018 and overall the trust was rated as requires improvement with safe, effective and responsive being rated as requires improvement and caring rated as good.

We carried out a comprehensive inspection of urgent and emergency care, medicine, surgery, critical care, maternity, services for children and young people, outpatients and diagnostic imaging from 24 to 27 September 2019. We carried out an unannounced inspection on the 10 October 2019.

At the time of inspection Diana Princess of Wales Hospital had approximately 439 inpatient beds. In addition, the hospital provides critical care services, with 13 beds available for intensive care and high dependency, close to the main theatre complex.

The trust services are commissioned by the following Clinical Commissioning Groups (CCG's), who commission the majority of the trust's services, and also local authorities.

- Northern East Lincolnshire CCG.
- North and North East Lincolnshire CCG.
- East Riding of Yorkshire CCG.
- North East Lincolnshire council.

Summary of services at Diana Princess of Wales Hospital

Requires improvement   

Our rating of services stayed the same. We rated it them as requires improvement because:

Summary of findings

- There had been little progress identified in this inspection and in some services a deterioration.
- Within outpatients continued backlogs were identified and within diagnostic imaging there was also an increased backlog of patient awaiting diagnostic image services and the subsequent reporting of x-rays. There were unknown risks due to these backlogs.
- There had been incidents where patients had come to harm due to delays in receiving appointments in both outpatients and diagnostic imaging. We had significant concerns regarding this and after the inspection, the Care Quality Commission completed a section 31 letter of intent to seek further clarification from the trust.
- Within end of life we were concerned about the timeliness of pain relief given to patients and lack of documentation which would enable to trust to monitor the effectiveness of care and treatment and drive improvement.
- Across most services there was still insufficient numbers of staff within the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment.
- The service provided mandatory training in key skills to staff but had not ensured everyone had complete it. Across most services there were continued low levels of mandatory training.
- We had ongoing concerns that patients with mental health conditions were not always cared for in a safe environment.
- Within the emergency department there were significant numbers of black breaches and the department failed to meet the medium time to initial assessment.
- Critical care services did not always manage infection control risks.
- The services did not always provide care and treatment in line with national guidance and best practice. We found examples of this in some of the core services inspected.
- The services did not ensure that staff were competent to carry out their roles and compliance with annual appraisals continued to be low.
- Services were not always planned to meet the needs of local services. This was particularly so in end of life services.
- Waiting times, referral to treatment and arrangements to admit, treat and discharge across a number of core services continued to be a challenge. People could not always access the services when they needed to.
- Investigations of complaints were not managed in a timely way and in line with trust policy.
- Across most services there continued to be a lack of clear strategies at this level.
- Systems to manage performance were not consistently used to improve performance.
- There continued to be changes in the governance structures and processes which had not become embedded and therefore there was limited oversight.
- There was limited evidence of continuous improvement and innovation across most core services.

However:

- Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.
- Overall staff felt respected, supported and valued.
- Most services had an open culture where patients, their families and staff could raise concerns without fear.

Urgent and emergency services

Requires improvement   

Key facts and figures

The trust provides trauma units at its Diana, Princess of Wales Hospital (DPoW) and Scunthorpe General Hospital (SGH) Emergency Care Centres (ECCs) which are part of the Yorkshire and Humber region. Adult major trauma and paediatric major trauma are provided at other acute NHS trusts.

SGH provides hyper acute stroke services for the trust. ECCs are consultant led with consultants available either directly in the department or on call out of hours.

Cover for gastrointestinal (GI) bleeds is currently provided on both sites. DPoW and SGH have acute medical units led by acute care physicians from 08:30 to 17:00 Monday to Friday. Outside of these hours an on call physician provides consultant presence. Consultant cover weekends is 08:00 to 20:00, then cover as on call.

DPoW has an ambulatory emergency care facility led by Medical Acute Care Physicians (ACP's).

Following our inspection in 2018 we said:

- The trust must continue to appropriately recruit medical staff to ensure that there are sufficiently suitably qualified, competent and experienced staff on duty to meet the needs of patients. The department was not in line with the Royal College of Emergency Medicine (RCEM) guidance of providing 16-hour consultant cover.
- The trust must ensure that all staff complete mandatory training to meet the trust's set standard of 85%.
- The trust must ensure that all staff have an up to date appraisal completed.
- The trust must continue to appropriately recruit staff (specifically registered sick children's nurses (RSCN)) and ensure that there are sufficiently suitably qualified, competent and experienced staff on duty to meet the needs of patients. The emergency department was not meeting the Intercollegiate Emergency Standard to have sufficient RSCNs to provide one per shift.

At our inspection 24 to 27 September 2019, we followed key lines of enquiry and rated all five key questions; safe, effective, caring, responsive and well led.

We visited the emergency department at Diana Princess of Wales Hospital (DPoW).

We observed care and treatment, looked at 35 complete patient records, 25 medication administration records. We also spoke with medical and nursing staff, ambulance personnel and the senior management team who were responsible for leadership and oversight of the service. We spoke with 30 patients, 14 relatives and 30 members of staff.

We looked at the environment within the department, handovers and safety briefings. We also reviewed the hospital's performance data in respect of the emergency department.

Summary of this service

Our rating of this service stayed the same. We rated it as requires improvement because:

- Whilst the service provided mandatory training in key skills including the highest level of life support training, staff in the department had not all completed the training. This included basic and advanced life support training for children and adults and safeguarding training.

Urgent and emergency services

- The design of the department did not meet the requirements to keep all patients safe. We had ongoing concerns that the design of the department was not psychiatric liaison accreditation network (PLAN compliant).
- The time from arrival to initial assessment was worse than the overall England median in all months over the 12-month period from April 2018 to March 2019. From June 2018 and May 2019 there was an upward trend of ambulances handovers of more than 30 minutes however following our inspection information provided by the trust showed that from April 2019 to November 2019 there had been improvement in this metric. There had been 1,410 black breaches from June 2018 to May 2019.
- We found oxygen was not always prescribed before being administered in line with the trusts policy.
- The service did not have enough substantive medical or nursing staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment, however bank, agency and locum staffing was used to fill most roster gaps. At the previous inspection the department had insufficient numbers of nursing and medical staff.
- There was not enough registered sick children's nurses (RSCNs) to meet the intercollegiate emergency standard.
- At the previous inspection we found that the department was not in line with the Royal College of Emergency Medicine (RCEM) guidance of providing 16-hour consultant covert this inspection we saw that this was still not being met.
- At our inspection in 2018, we found the department did not meet the RCEM audit standards 2016/17 for moderate and acute severe asthma, consultant sign off and severe sepsis and septic shock. At this inspection we found the service had completed internal audits to monitor progress against the RCEM audit standards. We found some improvement against some standards, but this was not consistent across all the required standards.
- The service did not always make sure staff were competent for their roles. Appraisal of staffs work performance was not in line with the trusts target for medical or nursing staff.
- The trust was not meeting the time of arrival to receiving treatment of less than one hour. The trust did not meet the standard for 11 months over the 12-month period from April 2018 to March 2019.
- The national standard for emergency departments of 95% of patients being admitted, transferred or discharged within four hours of arrival was not met and data demonstrated a deteriorating picture up to September 2019 with an overall performance of 78.4% of patients meeting the four-hour target.
- Whilst the service treated concerns and complaints seriously, the time taken to investigate, share lessons learned with staff and feedback to the complainant was not in line with the trusts policy. The time taken to investigate, complaints and share lessons learned with all staff and provide feedback to the complainant was not in line with the trusts policy.
- Whilst the service leaders understood the priorities and issues the service faced there had been limited improvements made since our last inspection.
- The service had a vision for what it wanted to achieve, however the strategy to turn it into action was not yet in place despite this being identified as a concern at our previous inspection.
- We saw limited evidence that leaders and teams used systems to manage performance effectively. Whilst some risks and issues were identified and escalated, there was limited evidence to show actions to reduce their impact and not all of the identified risks were on the risk register.
- There was limited examples of learning, continuous improvement and innovation.

However:

- The service controlled infection risk well. They kept equipment and the premises visibly clean.

Urgent and emergency services

- The service managed patient safety incidents well.
- The service provided care and treatment based on national guidance and evidence-based practice.
- Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. The service made adjustments for patients' religious, cultural and other needs.
- Staff assessed and monitored patients regularly to see if they were in pain and gave pain relief in a timely way.
- Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent.
- Staff worked well together for the benefit of patients, advised them on how to lead healthier lives, supported them to make decisions about their care, and had access to good information. Key services were available seven days a week.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.
- The service planned care to meet the needs of local people, took account of patients' individual needs, and made it easy for people to give feedback.

Is the service safe?

Inadequate  

Our rating of safe went down. We rated it as inadequate because:

- Whilst the service provided mandatory training in key skills including the highest level of life support training, staff in the department had not all completed the training. This included basic and advanced life support training for children and adults.
- The design of the department did not meet the requirements to keep all patients safe. At the previous inspection the mental health assessment room did not meet the Psychiatric Liaison Accreditation Network (PLAN). At this inspection the mental health assessment room was still not PLAN compliant.
- The time from arrival to initial assessment was worse than the overall England median in all months over the 12-month period from April 2018 to March 2019. . From June 2018 and May 2019 there was an upward trend of ambulances handovers of more than 30 minutes however following our inspection information provided by the trust showed that from April 2019 to November 2019 there had been improvement in this metric. There had been 1,410 black breaches from June 2018 to May 2019.
- We had concerns that compliance with safeguarding training for both medical and nurse staff was low. In addition, some nursing staff were unable the electronic system to check if children in their care were at risk.
- The service did not have enough substantive medical or nursing staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment, however bank, agency and locum staffing was used to fill most roster gaps. At the previous inspection the department had insufficient numbers of nursing and medical staff.
- There was still not enough registered sick children's nurses (RSCNs) to meet the intercollegiate emergency standard. Fifty percent of staff had not completed paediatric competencies despite this being an ongoing concern since 2016.

Urgent and emergency services

- At the previous inspection we found that the department was not in line with the Royal College of Emergency Medicine (RCEM) guidance of providing 16-hour consultant cover. This inspection we saw that this was still not being met.
- We found oxygen was not always prescribed before being administered in line with the trusts policy.

However:

- The service controlled infection risk well. They kept equipment and the premises visibly clean.
- Staff completed risk assessments for each patient once they were seen in the department.
- The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service.

Is the service effective?

Requires improvement   

Our rating of effective stayed the same. We rated it as requires improvement because:

- Whilst staff monitored the effectiveness of care and treatment, we were not assured the service used the findings to make improvements and achieved good outcomes for patients.
- At this inspection we found the service had completed internal audits to monitor progress against the RCEM audit standards. We found some improvement against some standards, but this was not consistent across all the required standards.
- The service did not consistently assure staff were competent for their roles. Managers did not always appraise staff's work performance.
- The service was not meeting the trust target for mental capacity act and deprivation of liberty training.
- The departments unplanned re-attendance rate within seven days was worse than the national standard and worse than the England average.

However:

- The service provided care and treatment based on national guidance and evidence-based practice.
- Staff gave patients enough food and drink to meet their needs and improve their health.
- Staff assessed and monitored patients regularly to see if they were in pain and gave pain relief in a timely way.

Is the service caring?

Good   

Our rating of caring stayed the same. We rated it as good because:

- Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.
- Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs.

Urgent and emergency services

- Staff supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment.

However:

- The department scored below the England average in the Friends and Family Test (FFT).

Is the service responsive?

Requires improvement  

Our rating of responsive went down. We rated it as requires improvement because:

- Whilst the service was planned to meet the needs of local people, improvement in performance had been limited due to the department's ability to meet the demands of the service.
- The trust consistently failed to meet the national four-hour standard for all patients to be seen and transferred or discharged. From April 2018 to March 2019 the four hour target was only met in one month. The overall performance was 78.4% of patients meeting the four-hour target compared with the national standard of 95%.
- From April 2018 to March 2019 the longest median time to treatment was in July 2018, was 74 minutes compared to the England average of 64 minutes.
- From June 2018 to May 2019, the trust's monthly median total time in urgent and emergency care for all patients was slightly worse than the England average.
- Whilst the service treated concerns and complaints seriously, the time taken to investigate, share lessons learned with staff and feedback to the complainant was not in line with the trusts policy. The time taken to investigate, complaints and share lessons learned with all staff and provide feedback to the complainant was not in line with the trusts policy.

However:

- The service was planned to meet the needs of local people and the communities served.
- The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.

Is the service well-led?

Requires improvement  

Our rating of well-led went down. We rated it as requires improvement because:

- Although leaders understood the priorities and issues the service faced there had been limited improvements made since our last inspection.
- Although the service had a vision for what it wanted to achieve, the strategy to turn it into action was not yet in place despite this being identified as a concern at our previous inspection.
- We saw limited evidence that leaders and teams used systems to manage performance effectively. Whilst some risks and issues were identified and escalated this was not consistent. For some risks there was limited evidence to show actions to reduce their impact were effective and not all risks and concerns were evident on the risk register

Urgent and emergency services

- Leaders and staff did not always engage with patients, staff, equality groups, the public and local organisations to plan and manage services. We had some concerns raised about the support provided by senior medical staff.
- There were limited examples of learning and improving services. Staff had a good understanding of quality improvement but there was limited evidence of any improvements made since our previous inspection.

However:

- Nursing staff had regular opportunities to meet, discuss and learn from the performance of the service.
- Most nursing staff felt respected, supported and valued. They were focused on the needs of patients receiving care.

Areas for improvement

We found areas for improvement in this service. See the Areas for Improvement section above.

Medical care (including older people's care)

Requires improvement   

Key facts and figures

Diana, Princess of Wales Hospital is part of the Northern Lincolnshire and Goole NHS Foundation Trust and is in Grimsby, North East Lincolnshire. It provides a range of care services for patients in Grimsby and the surrounding areas, but for some acute services such as stroke thrombolysis and percutaneous coronary intervention (PCI), patients are transferred to Scunthorpe General Hospital (SGH).

The hospital's medical division provides care in the specialities of: general medicine; care of the elderly; respiratory medicine; gastroenterology including endoscopy services; diabetes and endocrinology; cardiology; oncology, haematology and rheumatology; and stroke care and rehabilitation. The hospital has 203 medical inpatient beds located across eight wards.

We previously inspected this service in May 2018 and rated it as requires improvement. This inspection was announced (staff knew we were coming) and took place from 24 to 27 September 2019. During our inspection we visited the general and speciality wards, the acute medical unit (AMU) including ambulatory care and the escalation area, the stroke unit and the endoscopy unit. We observed care and treatment being delivered, analysed performance information and reviewed patient care documentation. We spoke with 29 members of staff, 24 patients and six relatives. We looked at 15 complete patients records, 16 prescription charts, and specific documentation relating to consent, mental capacity assessments, and Deprivation of Liberty Safeguards.

We returned to the hospital on 10 October 2019 for a follow-up inspection which was unannounced (staff did not know we were coming). We revisited AMU, the escalation area and ward C2. We spoke with a further nine members of nursing and medical staff and reviewed an additional three prescription charts.

Summary of this service

Our rating of this service stayed the same. We rated it as requires improvement because:

- The service provided training in key skills to all staff but not all staff had completed it. We were not assured the service always had enough staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Records were not always stored and disposed of securely. Medicines were not always managed safely.
- Data submission and compliance with audits were sometimes poor. Annual appraisal compliance did not meet the trust's target for all staff.
- Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were not in line with national standards.
- The strategy for the medical division was still in draft format. Concerns remained about the pace of change and improvement implementation. We were not assured about management oversight in some areas.

However:

- The service-controlled infection risk well. Staff completed and updated risk assessments for patients and removed or minimised risks. The service managed patient safety incidents well.

Medical care (including older people's care)

- The service provided care and treatment based on national guidance. Staff gave patients enough food and drink to meet their needs and improve their health. Staff assessed and monitored patients' pain regularly and worked together to benefit patients. Staff supported patients to make informed decisions about their care and treatment.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. They provided emotional support to patients, families and carers.
- The service took account of patients' individual needs. It was easy for people to give feedback and raise concerns about care received.
- Leaders had the skills and abilities to run the service. Staff mostly felt respected, supported and valued. The service had systems to identify risks.

Is the service safe?

Requires improvement   

Our rating of safe stayed the same. We rated it as requires improvement because:

- The service provided mandatory training in key skills to all staff but not all staff had completed it. Mandatory training compliance did not meet the trust target of 85% for nursing or medical staff. This was highlighted at our last inspection.
- Nursing staff were not compliant with two of the six safeguarding training modules; medical staff were not compliant with five of the six safeguarding training modules.
- The use of facilities and premises did not always keep people safe; we had several concerns about the escalation area adjacent to AMU.
- We were not assured the service always had enough staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment; nursing staff were often relocated which depleted skill mix, we had concerns about overnight shift cover and support for junior doctors, and the service had a medical vacancy rate of 26.5% at the time of our inspection.
- Paper records were not always managed appropriately: we found patients' notes and confidential paper waste were not stored or disposed of securely in some areas, and items of version-controlled patient documentation were out of date.
- We were not assured of safe medicines management in all areas: we found take-home prescriptions for controlled drugs were not routinely recorded; medicines were not always stored securely; and oxygen was not always prescribed in line with guidance.

However:

- Staff we spoke with understood how to protect patients from abuse and worked well with other agencies to do so.
- The service-controlled infection risk well. Staff kept equipment and the premises visibly clean. Staff were trained to use equipment and managed clinical waste well.
- Staff completed and updated risk assessments for patients; we saw documentation was completed clearly and improvements had been made in risk management relating to falls and pressure area care.

Medical care (including older people's care)

- The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned. When things went wrong, staff apologised and gave patients honest information and suitable support.

Is the service effective?

Good  → ←

Our rating of effective stayed the same. We rated it as good because:

- The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance. Staff protected the rights of patients, subject to the Mental Health Act 1983.
- Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. The service made adjustments for patients' religious, cultural and other preferences. The patient-led assessment of the care environment (PLACE) scores for ward food and nutritional support were higher than the national average. A nutritional support specialist nurse role had recently been introduced.
- Staff assessed and monitored patients regularly to see if they were in pain and gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.
- The endoscopy service had been accredited by the Joint Advisory Group and staff worked hard to maintain high standards. There was a 24-hours a day, seven days a week gastrointestinal bleed rota in place.
- Staff of different grades and disciplines worked together as a team to benefit patients. Doctors, nurses and other healthcare professionals supported each other and communicated well to provide good patient care.
- Key services were available seven days a week to support timely patient care.
- Staff gave patients practical support and advice to lead healthier lives.
- Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health. They used agreed personalised measures that limited patients' liberty.

However:

- Data submission and compliance with audits were sometimes poor.
- Staff appraisal compliance did not meet the trust target. This issue was highlighted at our last inspection.
- Mental Capacity Act and Deprivation of Liberty Safeguards training compliance did not meet the trust target. Nursing staff met one out of two training modules, whilst medical staff failed to meet both modules.

Is the service caring?

Good  → ←

Our rating of caring stayed the same. We rated it as good because:

Medical care (including older people's care)

- Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs. We observed many interactions between staff, patients and others during our inspection. We found all staff to be polite, respectful, professional and non-judgmental in their approach.
- Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs. Patients told us they felt very well supported and said staff were attentive and listened to their needs.
- Staff supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment. Patients and those close to them told us they felt involved in the planning and implementation of care and they had been given clear information.

However:

- Although patients told us that staff always respected their privacy and dignity, the PLACE score for privacy, dignity and wellbeing was lower than the national average.

Is the service responsive?

Requires improvement   

Our rating of responsive stayed the same. We rated it as requires improvement because:

- Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were not in line with national standards.
- The medicine division's referral to treatment time within 18 weeks for admitted pathways was worse than the England average for all specialities. This was highlighted at the last inspection and we were not assured the trust was working at pace to improve this.
- The average length of stay for elective patients in gastroenterology and cardiology were both higher than the England average.
- The average lengths of stay for non-elective patients in general medicine and respiratory medicine were higher than the England averages.
- The position of lead nurse for frailty had not been recruited into and because of this there was no consistent frailty service within the hospital.

However:

- The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.
- Staff told us the introduction of the care navigator role had improved the patient discharge process.
- At our last inspection we found that, during 2017, 308 patients moved wards at night. At this inspection, from June 2018 to May 2019, 123 patients had moved wards at night.
- It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint.

Medical care (including older people's care)

Is the service well-led?

Requires improvement ● → ←

Our rating of well-led stayed the same. We rated it as requires improvement because:

- Although leaders understood the service's priorities and issues, there had been limited improvements made since our last inspection; we were concerned about lack of management oversight and pace of change.
- At our last inspection we said the trust must ensure medical and nursing staff comply with mandatory training requirements. At this inspection we found mandatory training compliance targets, including those for safeguarding training, were still not being met.
- At our last inspection we said the trust must ensure safe medical staffing levels were maintained and hospital at night arrangements should be reviewed. At this inspection we continued to see a high number of medical vacancies and were told that overnight medical cover and support for junior doctors was still a concern.
- At our last inspection we said the trust must ensure safe medicines management; at this inspection we had concerns around controlled drugs' prescriptions, lack of oxygen prescribing and safe storage of medicines.
- We saw limited evidence that leaders and teams used systems to manage performance effectively. At our last inspection we said the trust must improve its referral to treatment time for medical patients. The trust's RTT performance had deteriorated since the last inspection and we were not assured the senior leadership team were moving at pace to improve.
- Although the service had a vision for what it wanted to achieve, the strategy to turn it into action was not yet in place despite this being identified as a concern at our previous inspection.
- The service did not always store or dispose of confidential paper records securely and some version-controlled documentation was out of date. We found this issue in several areas so were not assured there was management oversight.
- Staff had a good understanding of quality improvement and there was some evidence of improvements made since our previous inspection.

However:

- Leaders had the skills and abilities to run the service. They were visible and approachable for patients and staff. They supported staff to develop their skills and take on more senior roles.
- Staff were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work and provided opportunities for career development. There was an open culture where patients, their families and staff could raise concerns without fear; this was an improvement from our last inspection.

Areas for improvement

We found areas for improvement in this service. See the Areas for Improvement section above

Surgery

Requires improvement   

Key facts and figures

Surgical services are provided across all three hospital sites. At the Diana, Princess of Wales Hospital (DPoW) and Scunthorpe General Hospital (SGH) site the trust delivers a fully comprehensive surgical service which includes general surgery, breast, colorectal, upper gastrointestinal, trauma and orthopaedics, ophthalmology, ear, nose and throat (ENT), orthodontics, oral-maxillofacial, urology, pain services and pre-assessment.

There are six theatres at SGH and nine theatres at DPoW, including one obstetric theatre on each site. At the DPoW site there are two theatres dedicated to trauma and orthopaedic use (both with ultra clean air facility). At the SGH site there is one theatre with a laminar flow for trauma sessions seven days a week. One theatre is dedicated to emergency work and staffed at all times. A separate session for acute trauma cases is reserved each day, including weekends.

At Goole and District Hospital (GDH), surgical services provided include general surgery, orthopaedics, ophthalmology, ENT, urology and pain services. The two main theatres at GDH are equipped for major orthopaedic surgery as well as other types of surgery. In addition, the site has a well-equipped ophthalmic suite and theatre and also an outpatient department.

(Source: Routine Provider Information Request (RPIR) – AC1. Context acute tab)

The trust had 44,865 surgical admissions from March 2018 to February 2019. Emergency admissions accounted for 10,095 (22.5%), 31,243 (69.6%) were day case, and the remaining 3,527 (7.9%) were elective.

(Source: Hospital Episode Statistics)

Surgical services were last inspected in Diana, Princess of Wales Hospital in May 2018, where all five domains in surgery were inspected and an overall rating of requires improvement was given. Well led was rated as inadequate, safe, effective, responsive were all rated as requires improvement and caring was rated as good.

The main areas of concern from the last inspection and the areas in surgery where the trust was told to improve were:

- The trust must ensure that performance in all national audits improves and that action plans address the correct issues to ensure performance improves.
- The trust must improve on national treatment performance standards.
- The trust must ensure that there are sufficient qualified, competent, skilled and experienced persons to meet the needs of patients using the services.
- The trust must ensure that patients are fasted pre-operatively in line with best practice recommendations.
- The trust must ensure that medicines are prescribed and administered in line with national guidance.
- The trust must ensure that effective processes are in place to reduce the number of cancelled operations.
- The trust must ensure that policies and guidelines in use within clinical areas are compliant with National Institute for Health and Care Excellence (NICE) or other clinical bodies.
- The trust must continue to ensure that a patient's capacity is clearly documented and where a patient is deemed to lack capacity this is assessed and managed appropriately in line with the Mental Capacity Act (2015).

We also said that the trust should:

Surgery

- The trust should continue to ensure that effective processes are in place to enable access to theatres out of hours, and that all cases are clinically prioritised appropriately.
- The trust should continue to ensure that actions are taken to enable staff to raise concerns without fear of negative repercussions.
- The trust should continue to ensure that patients are assessed for delirium in line with national guidance.
- The trust should ensure that staff complete Mental Capacity Act training.

During the inspection, we visited the surgical wards, operating theatres and recovery areas, the pre-assessment ward and the day surgery unit. We spoke with 10 patients and 27 members of staff. We observed staff delivering care and reviewed 17 sets of patient records and prescription charts. We also reviewed trust policies and performance information, from and about the trust.

Summary of this service

Our rating of this service stayed the same. We rated it as requires improvement because:

- The division did not move with enough pace to address the issues from the previous inspection. We were not able to see the impact of change on all areas we raised at the last inspection.
- The service did not always have enough medical staff to care for patients and keep them safe. The service provided staff with training in key skills but did not have effective systems and processes to ensure this was completed; compliance was particularly poor for medical staff and safeguarding training compliance was below the trust target. Records were poorly organised, not always completed and version control was poor. The service did always respond to safety incidents well or in a timely way.
- The service did not always provide care and treatment in line with national guidance and best practice. We found examples of patients being fasted for longer than the recommended time and malnutrition universal screening tool (MUST) scores were not recorded in line with policy. Appraisal rates did not meet the trust target.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. They provided emotional support to patients, families and carers.
- In the service, we found that patients whose operations were cancelled were not always treated within 28 days and some patients were still waiting more than 52 week waits for surgical treatment. Medical outliers did not always receive timely medical reviews and the trust continued to breach mixed sex accommodation in the high observation bay (HOBs) area. The trust had a backlog of complaints and the average complaints response took 119.8 working days; the trust policy is 60 working days
- Systems to manage performance were not consistently used to improve performance. We saw limited evidence of identifying and escalating relevant risks and issues and identified actions to reduce their impact. We did not see governance, performance or risk issues escalated and discussed in an effective way. The governance structure internally within the division and externally within the trust needed strengthening to show evidence of risk and performance discussion. We saw limited evidence that the draft vision and strategy had been developed with all relevant stakeholders.

However:

Surgery

- Staff understood how to protect patients from abuse, and managed safety well. The service controlled infection risk well. Staff assessed risks to patients, acted on them. They managed medicines well. Staff recognised and reported some incidents and near misses and managers investigated incidents appropriately and shared lessons learned.
- Staff provided good care and treatment, gave patients enough to eat and drink, and gave them pain relief when they needed it. Managers monitored the effectiveness of the service and made sure staff were competent. Staff worked well together for the benefit of patients, advised them on how to lead healthier lives, supported them to make decisions about their care, and had access to good information. Key services were available seven days a week.
- The service planned care to meet the needs of local people, took account of patients' individual needs, and made it easy for people to give feedback. People could access the service when they needed it.
- Leaders and teams had systems to manage performance. The service had a vision for what it wanted to achieve and had developed a draft strategy to turn it into action. The culture in the division had improved and staff were focused on the needs of patients receiving care.

Is the service safe?

Requires improvement   

Our rating of safe stayed the same. We rated it as requires improvement because:

- The service did not always have enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed the risk to the service; however, sickness and vacancies rates were increasing in the service and locum doctor hours were reducing.
- The service had declared serious incidents relating to missed appointments and referrals because of a backlog people waiting for outpatients' appointments; we were not assured this risk was mitigated and would not reoccur.
- The division did not always respond to incidents appropriately or in a timely way, and there was not always appropriate oversight of incident themes and trends.
- During the inspection we did not see call bells in the pre-assessment ward area for patients to call for help if they needed it. However, post inspection the trust provided information to show that they had reviewed this and that all rooms, with the exception of one, had a call bell in place.
- There were limited systems and processes to manage deteriorating patients including resuscitation equipment in the pre-assessment ward. Staff were not confident in where to find this equipment if they needed it in an emergency situation. Resuscitation equipment was rectified following the inspection visit.
- The service did not have effective systems and processes to ensure mandatory training was completed by all staff. Compliance rates were particularly poor for medical staff.
- The service did not have effective systems and processes to ensure safeguarding training was completed by all staff. Compliance rates were particularly poor for medical staff.
- There was little evidence of stock rotation and management and we found out of date stock across wards.
- There was limited storage on the wards for equipment, stock and staff belongings.
- Not all patients requiring pre-assessment to ophthalmology surgery received this, which meant operations were cancelled.

Surgery

- Records were poorly organised, and documentation relating to surgery was not always completed.
- Record version control was poor, and we found examples of documentation past its review date in use.

However:

- The service controlled infection risk well. The service used systems to identify and prevent surgical site infections. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean. The maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well.
- Staff completed and updated risk assessments for each patient and removed or minimised risks. Staff identified and quickly acted upon patients at risk of deterioration.
- The service had enough nursing and support staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix.
- Staff kept detailed records of patients' care and treatment. Records were up-to-date, stored securely and easily available to all staff providing care. The service used systems and processes to safely prescribe, administer, record and store medicines.
- Managers investigated incidents and shared lessons learned with the team. When things went wrong, staff apologised and gave patients honest information and suitable support.

Is the service effective?

Requires improvement   

Our rating of effective stayed the same. We rated it as requires improvement because:

- The service did not always provide care and treatment based on national guidance and evidence-based practice; a number of policies were not compliant.
- Staff did not always follow national guidelines to make sure patients fasting before surgery were not without food for long periods. Patients malnutrition universal screening tool (MUST) scores were not recorded in line with the trust's procedure and fluid and food balance charts were not accurately documented.
- Appraisal rates for staff did not meet the trust target of 95%, however this was improving. Staff were not always given time or opportunities to complete additional training and clinical education sisters on the wards did not have facility time to implement education on the wards, so it was not consistent. However, the service was assured staff were competent in their roles.
- Mental Capacity Act training compliance did not meet the trust target; medical staff compliance was significantly below the trust target.
- Documentation of consent was not always completed in line with national guidance to gain patients' consent. Patients were not always re-consented on the day of surgery and patient consent forms were not always shared with them in line with the trust policy.

However:

Surgery

- Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. The service made adjustments for patients' religious, cultural and other needs.
- Staff assessed and monitored patients regularly to see if they were in pain and gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.
- Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care. Staff told us they felt support by managers. Key services were available seven days a week to support timely patient care. Staff gave patients practical support and advice to lead healthier lives.
- Staff supported patients to make informed decisions about their care and treatment. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health. They used agreed personalised measures that limited patients' liberty.

Is the service caring?

Good   

Our rating of caring stayed the same. We rated it as good because:

- Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.
- Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs.
- Staff supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment.

However:

- The friends and family test response rate was 15%, which was lower than the national average of 27%.

Is the service responsive?

Requires improvement   

Our rating of responsive stayed the same. We rated it as requires improvement because:

- The service continued to breach mixed sex accommodation in the high observation bay (HOBs) area.
- The service did not always treat patients within 28 days when operations were cancelled on the day of surgery which was a breach of the standard.
- There were large numbers of patient's operations being cancelled on the day of surgery, however this had improved since the last inspection and was on a downward trend.
- The trust had a backlog of complaints and the average complaint response took 119.8 working days at Diana, Princess of Wales hospital; the trust policy was 60 working days.
- Wards with high numbers of medical outliers did not always have regular medical reviews which delayed care received and discharges.

Surgery

However:

- The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.
- The service took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.
- The service had a surgical ambulatory ward helped to avoid unnecessary patient admissions to hospital and improved flow to theatre wards and a surgical admissions lounge which helped increase flow to theatres.
- It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff.

Is the service well-led?

Requires improvement  

Our rating of well-led improved. We rated it as requires improvement because:

- The service had a vision for what it wanted to achieve and had developed a draft strategy to turn it into action, however we saw limited evidence that this had been developed with all relevant stakeholders.
- The division had limited evidence to show that all areas requiring improvement from the last inspection had been acted upon, embedded or sustained.
- Leaders had governance processes, however we did not see issues escalated and discussed in an effective way. The governance structure internally within the division and externally within the trust needed strengthening to show evidence of risk and performance discussion.
- Leaders and teams had systems to manage performance. However, these were not consistently used to improve performance. We saw limited evidence of identifying and escalating relevant risks and issues and identified actions to reduce their impact.

However:

- At this inspection we saw more stability within leadership roles. Since the last inspection the senior management team had undergone further changes. These changes had an impact on the decision making, pace of change, governance and oversight of the issues within surgery.
- Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service, however some of the discussion were limited.
- Staff moral had improved; staff we spoke with said that they felt supported by the senior leaders.

Areas for improvement

We found areas for improvement in this service. See the Areas for Improvement section above.

Critical care

Requires improvement   

Key facts and figures

Northern Lincolnshire and Goole NHS Foundation Trust has two critical care units. Diana, Princess of Wales Hospital has a six-bedded level two and three intensive care facility. This provides level two (patients who require preoperative optimisation, extended post-operative care or single organ support) and level three (patients who require advanced respiratory support or a minimum of two organ support) care. The intensive care unit (ICU) had a bay containing four beds and two single rooms. The beds flexed between level two and level three as required. The unit could care for a maximum of six level three patients. This site also has a separate seven-bedded high dependency unit (HDU), which provides level two care.

A critical care outreach team provided a supportive role to the wards medical and nursing staff when caring for deteriorating patients and support to patients discharged from critical care. The team was available seven days a week.

The critical care service is part of the East Yorkshire and Humberside Critical Care Network. The units did not accept paediatric admissions. However, they held paediatric resuscitation equipment in the event of an emergency or if a young person required stabilisation prior to a transfer.

The anaesthetist or consultants would attend in an emergency and stabilise the patient until a bed was available on the neonatal ICU or until the dedicated intensive care transport service for children arrived. The unit had an inter hospital transfer policy which was in line with the critical care network and national guidelines.

Our inspection was part of an announced comprehensive inspection of the whole trust, this was due to it being in special measures.

We re-inspected all five key questions during this inspection. We visited the intensive care unit and the high dependency unit. We spoke with three relatives and 14 members of staff. It was not appropriate to speak to any of the patients at the time of the inspection.

We observed staff delivering care, looked at nine patient records and four prescription charts. We reviewed trust policies and performance information from, and about, the trust. We received comments from three relatives and members of the public who contacted us directly to tell us about their experiences.

Summary of this service

Our rating of service stayed the same. We rated it as requires improvement because:

- The service did not have enough nursing and support staff. Not all had the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Information provided by the trust showed that 37% of nurses in ICU had a post registration award in critical care nursing. Several staff we spoke with highlighted that whilst the number of staff on duty was appropriate, the mix of skills and competence was sometimes a concern.
- The service did not have enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. We found the same situation with regards to medical staffing as at the previous inspection, in that it was not in line with Guidelines for the Provision of Intensive Care Services (GPICS) standards. Not all care was delivered by intensivists, and on call consultants had other areas of responsibility. In addition, the rota did not provide continuity of care for patients.

Critical care

- Staff did not always have measures in place to keep people free from infection. ICNARC data showed there had been six unit acquired infections between 1 April 2018 and 31 March 2019. This was higher compared to similar units (3.0 against 1.6 unit acquired infections in blood per 1000 patient bed days). Observations of hand hygiene frequency was variable between staff on the ICU. On three occasions, between January 2019 and September 2019, the hand hygiene audit dropped below the trust target of 85%. On one occasion compliance was 74%. Hand hygiene data for the HDU showed that there were two occasions between January 2019 and September 2019 when the compliance rate did not meet the target of 85%.
- The service provided mandatory training in key skills to staff but had not ensured everyone had complete it. The 85% target was not met for three of the 10 mandatory training modules for which qualified nursing staff were eligible.
- Not all staff had training on how to recognise and report abuse. The 85% target was not met for two out of three safeguarding training modules for which qualified nursing staff and medical staff were eligible.
- Although, the service used systems and processes to safely prescribe, administer, and record medicines. We had concerns regarding the inappropriate storage of medicines on the ICU. All fluids were stored appropriately on HDU, however there were potassium based fluids stored alongside other IV fluids. This did not adhere to the trust policy.
- Critical care services did not always provide care and treatment based on national guidance and evidence-based practice. Information from the July 2019 governance meeting minutes showed that the division were not meeting compliance against all the National Institute for Health and Care Excellence (NICE) guidance, with a few outstanding. However, the minutes were not specific to which NICE guidance this linked to.
- Not all services were available seven days a week to support timely patient care. ICU medical team reviewed all patients at the weekend. Out of hours cover was provided by an anaesthetist on call or the medical out of hours team and not by an intensivist as per GPICS standards.
- Doctors, nurses and other healthcare professionals did not always work together as a team to benefit patients. Multidisciplinary staffing was generally in line with GPICS recommendations; however, it did not meet the full recommendations. We observed that there was not always full attendance during multidisciplinary ward rounds.
- People could not access the service in a timely way. For the intensive care unit there were also 4.2% had a non-clinical transfer out of the unit. Compared with other units, non-clinical transfers for this unit was worse than expected. Similar units had an average of 1.3% non-clinical transfers.
- For the intensive care unit at there were 12.7% non-delayed, out-of-hours discharges to the ward. These are discharges which took place between 10:00pm and 6:59am. Compared with other units (4.4%), the unit's performance was significantly worse. This did not meet the national standard.
- For the high dependency unit at there were 12.7% non-delayed, out-of-hours discharges to the ward. Compared with other units (4.2%), the unit's performance was significantly worse. This did not meet the national standard.
- Investigations were not timely. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. At the time of inspection, there were six complaints open and under investigation. Two complaints relating to Diana, Princess of Wales Hospital (DPoW) had been closed. Of these, the trust took an average of 82.5 working days to investigate and close.
- From our observation and from speaking with staff, it was clear that staff lacked confidence in their immediate line managers leadership. We heard staff state that actions were not always followed up and that outcomes were slow. Nonetheless, all staff we spoke with felt able to escalate concerns. This was also highlighted on the previous inspection.
- The HDU and ICU continued to function separately and there remained limited inter-unit working.

Critical care

- Staff at some levels were not clear about their roles and accountabilities.
- There was limited improvement of leaders and staff engagement with patients and relatives. Limited work had been done to improve engagement with families and patients. However, the use of patient diaries was not embedded, and there was no support group for relatives.
- There was limited learning and improvement of services. We were provided with limited examples of innovative working. We were not aware of any involvement or participation in research.

However:

- The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.
- Staff completed and updated risk assessments for each patient and removed or minimised risks. Staff identified and quickly acted upon patients at risk of deterioration.
- The critical care outreach team (CCOT) provided cover seven days a week from 8am to 8pm. Overnight cover was provided by the hospital out of hours team.
- Managers appraised staff's work performance and held supervision meetings with them to provide support and development. Data submitted at the time of inspection showed that nursing and medical staff working on HDU and ICU at Diana, Princess of Wales Hospital had achieved an appraisal rate of 100% against a trust target of 95%.
- We found the processes for sepsis and delirium screening was undertaken in ICU and HDU.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.
- We saw evidence in patient records that care plans included assessment and interventions for any patients with additional needs. This information would be communicated to all staff during handovers.
- Leadership of the service was in line with Guidelines for the Provision of Intensive Care Services (GPICS) standards. From discussions with the leadership team it was clear they understood the current challenges and pressures impacting on service delivery and patient care.

Is the service safe?

Requires improvement   

Our rating of safe stayed the same. We rated it as requires improvement because:

- The service did not have enough nursing and support staff. Not all had the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Information provided by the trust showed that 37% of nurses in ICU had a post registration award in critical care nursing. Several staff we spoke with highlighted that whilst the number of staff on duty was appropriate, the mix of skills and competence was sometimes a concern.
- The service did not have enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. We found the same situation with regards to medical staffing as at the previous inspection, in that it was not in line with GPICS standards. Not all care was delivered by intensivists, and on call consultants had other areas of responsibility. In addition, the rota did not provide continuity of care for patients.

Critical care

- Staff did not always have measures in place to keep people free from infection. ICNARC data showed there had been six unit acquired infections between 1 April 2018 and 31 March 2019. This was higher compared to similar units (3.0 against 1.6 unit acquired infections in blood per 1000 patient bed days). Observations of hand hygiene frequency was variable between staff on the ICU. On three occasions, between January 2019 and September 2019, the hand hygiene audit dropped below the trust target of 85%. On one occasion compliance was 74%. Hand hygiene data for the HDU showed that there were two occasions between January 2019 and September 2019 when the compliance rate did not meet the target of 85%. However, the critical care units were visibly clean and tidy.
- The service provided mandatory training in key skills to staff but had not ensured everyone had complete it. The 85% target was not met for three of the 10 mandatory training modules for which qualified nursing staff were eligible.
- Not all staff had training on how to recognise and report abuse. The 85% target was not met for two out of three safeguarding training modules for which qualified nursing staff and medical staff were eligible.
- Concerns were raised at the time of the inspection regarding the promptness of equipment replacement when faulty.
- Although, the service used systems and processes to safely prescribe, administer, and record medicines. We had concerns regarding the inappropriate storage of medicines on the ICU. All fluids were stored appropriately on HDU, however there were potassium based fluids stored alongside other IV fluids. This did not adhere to the trust policy.

However:

- The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.
- Staff completed and updated risk assessments for each patient and removed or minimised risks. Staff identified and quickly acted upon patients at risk of deterioration.
- The critical care outreach team (CCOT) provided cover seven days a week from 8am to 8pm. Overnight cover was provided by the hospital out of hours team.

Is the service effective?

Requires improvement   

Our rating of effective stayed the same. We rated it as requires improvement because:

- The service did not always up to date with care and treatment based on national guidance and evidence-based practice. Information from the July 2019 governance meeting minutes showed that the division were not up to date with all the National Institute for Health and Care Excellence (NICE) guidance, with a few outstanding. However, the minutes were not specific to which NICE guidance this linked to.
- Not all services were available seven days a week to support timely patient care. ICU medical team reviewed all patients at the weekend. Out of hours cover was provided by an anaesthetist on call or the medical out of hours team and not by an intensivist as per GPICS standards.
- Several staff we spoke with highlighted that whilst the number of staff on duty was appropriate, the mix of skills and competence was sometimes a concern.
- The percentage of staff assessed as competent to use the ventilators across the critical care division was 91% as of September 2019. All staff had received theory training on the use of ventilators with three remaining staff members to complete the competency statement.

Critical care

- Although, staff supported patients to make informed decisions about their care and treatment, the information provided by the trust showed 80.4% of nursing and 79% of medical staff were compliant with MCA training. This did not meet the trust target of 85%.
- Doctors, nurses and other healthcare professionals did not always work together as a team to benefit patients. Multidisciplinary staffing was generally in line with GPICS recommendations; however, it did not meet the full recommendations. We observed that there was not always full attendance during multidisciplinary ward rounds.

However:

- Managers appraised staff's work performance and held supervision meetings with them to provide support and development. Data submitted at the time of inspection showed that nursing and medical staff working on HDU and ICU at Diana, Princess of Wales Hospital had achieved an appraisal rate of 100% against a trust target of 95%.
- We found the processes for sepsis and delirium screening was undertaken in ICU and HDU.

Is the service caring?

Good   

Our rating of caring stayed the same. We rated it as good because:

- Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs. Feedback from the patients and relatives we spoke with was positive. We observed members of staff providing care for patients' in a kind and compassionate way. Staff communicated with patients in a caring manner regardless of whether they were conscious or unconscious.
- Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs. The critical care outreach team said they provided psychological support as part of their role. Specialist nurses were also available to provide advice and support.
- Staff supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment. The patient records we reviewed showed evidence of patient and carer involvement. This was supported by patients and the families we spoke with.

Is the service responsive?

Requires improvement  

Our rating of responsive went down. We rated it as requires improvement because:

- People could not access the service in a timely way. For the intensive care unit there were also 4.2% had a non-clinical transfer out of the unit. Compared with other units, non-clinical transfers for this unit was worse than expected. Similar units had an average of 1.3% non-clinical transfers.
- For the intensive care unit at there were 12.7% non-delayed, out-of-hours discharges to the ward. These are discharges which took place between 10:00pm and 6:59am. Compared with other units (4.4%), the unit's performance was significantly worse. This did not meet the national standard.
- For the high dependency unit at there were 12.7% non-delayed, out-of-hours discharges to the ward. Compared with other units (4.2%), the unit's performance was significantly worse. This did not meet the national standard.

Critical care

- Investigations were not timely. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. At the time of inspection, there were six complaints open and under investigation. Two complaints relating to Diana, Princess of Wales Hospital (DPoW) had been closed. Of these, the trust took an average of 82.5 working days to investigate and close.
- The service did not have a critical care patient and relative support group. At the time of the inspection the use of patient diaries was not fully embedded. There was no overnight accommodation for relatives.

However:

- The most recent ICNARC quarterly quality report showed that ICU and HDU at Diana, Princess of Wales were better for the number of bed days of care, post eight-hour delay, compared to similar units. The HDU ICNARC figures showed that there were no non-clinical transfers out of the unit.
- We observed handovers taking place and discussed the process of completing transfer documents for patients going to ward areas. This was in line with National Institute for Health and Care Excellence (NICE) guidance CG50 acutely ill adults in hospital.
- We saw evidence in patient records that care plans included assessment and interventions for any patients with additional needs. This information would be communicated to all staff during handovers.

Is the service well-led?

Requires improvement   

Our rating of well-led stayed the same. We rated it as requires improvement because:

- From our observation and from speaking with staff, it was clear that staff lacked confidence in their immediate line managers leadership. We heard staff state that actions were not always followed up and that outcomes were slow. Nonetheless, all staff we spoke with felt able to escalate concerns. This was also highlighted on the previous inspection.
- The HDU and ICU continued to function separately and there remained limited inter-unit working.
- Staff at some levels were not clear about their roles and accountabilities.
- The vision and strategy were focused on sustainability. The vision for the unit was ultimately dependent on the long-term reconfiguration of critical care services across the two hospital sites of Scunthorpe and Grimsby. The leadership teams hope was for a combined unit with additional capacity at this site. The staff we spoke with had a mixed level of awareness of the vision and strategy for the units.
- Staff did not always feel respected, supported and valued. Staff could raise concerns without fear. We identified that morale on the ICU was mixed. This was impacting the team and had also presented some challenges in terms of training and education for staff.
- Some concerns were identified in relation to staff movement from critical care to other areas. At the last inspection we were assured managers were aware of this and were taking steps to resolve these issues. However, there appeared to be no improvement. All staff we spoke with told us they felt able to raise concerns and were aware of the importance of being open and honest to patients and relatives if there had been a mistake in their care.
- There was limited improvement of leaders and staff engagement with patients and relatives. Limited work had been done to improve engagement with families and patients. However, the use of patient diaries was not embedded, and there was no support group for relatives.

Critical care

- There was limited learning and improvement of services. We were provided with limited examples of innovative working. We were not aware of any involvement or participation in research.

However:

- Leadership of the service was in line with Guidelines for the Provision of Intensive Care Services (GPICS) standards. From discussions with the leadership team it was clear they understood the current challenges and pressures impacting on service delivery and patient care.
- Leaders and teams escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events.
- Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements.
- We saw that the divisional risk register was up to date and regularly reviewed.

Areas for improvement

We found areas for improvement in this service. See the Areas for Improvement section above.

Maternity

Requires improvement  

Key facts and figures

Northern Lincolnshire and Goole NHS Foundation Trust provides a range of maternity services for women at three acute hospital sites. The trust has 72 acute maternity beds located across six wards; four wards at Diana, Princess of Wales hospital, and two at Scunthorpe General hospital. At Goole and District Hospital, the hospital offers daily antenatal midwife led clinics with a weekly obstetric clinic, there is also a one-bedded midwifery-led birthing suite available on site.

At Diana, Princess of Wales Hospital, Grimsby, maternity services are provided within a dedicated, custom made family services building. The service offered is an LDRP (Labour, Delivery, Recovery and Postnatal) system of care; which allows a woman to labour and deliver in the same en-suite room.

There are 16 beds in single or two-bedded rooms, and 19 LDRP rooms. The unit also housed a dedicated operating theatre, a family bereavement room, a high dependency room, a mobile or active birth room, and a water-birth room.

Antenatal obstetric high-risk clinics are provided Monday to Friday. The antenatal day unit is available every day. Obstetric ultrasonography facilities are available to fully support screening programmes and fetal/maternal well-being surveillance.

Community midwives are based within Children's Centres across North East Lincolnshire and some of East Lincolnshire. Two community midwifery teams (Grimsby and Louth) provided maternity services at the hospital and to women and babies in the surrounding communities.

From April 2018 to March 2019, there were 2387 deliveries at Diana, Princess of Wales hospital, and 43 home births across Grimsby and Louth community services.

During our inspection, we visited the maternity unit and spoke with eight patients and their companions, and 29 members of staff. These included matrons, ward managers, doctors, midwives, and health care assistants. We observed care and treatment, looked at seven complete patient records, and five medicines charts. We also interviewed key members of staff, medical staff and the senior management team who were responsible for the leadership and oversight of the service.

Summary of this service

Our rating of this service went down. We rated it as requires improvement because:

- Not all staff were up to date with key mandatory training; including obstetric emergency, resuscitation, adults safeguarding, and Mental Capacity training. The service had not provided quarterly 'live' (unannounced) emergency skills and drills training, in line with trust policy. The use of band three (healthcare assistant) scrub practitioners in theatres was not compliant with national guidance. The appraisal rate for medical staff was low and did not meet trust target.
- Leaders and senior staff had the necessary experience and knowledge to lead effectively. Whilst, there had been instability within the team since our previous inspection, some of the leaders had worked in the service for many years. Staff did express concerns about leadership stability and the implementation of new models of care; and said morale within the service had wavered. The service did not have an agreed vision for what it wanted to achieve and the strategy to turn it into action was in draft. In addition, the divisional strategy was also in draft.

Maternity

- We were not assured leaders had oversight of clear and reliable midwifery and nurse staffing data; and we saw sickness rates and use of bank staff were high. Community caseloads, allowing for some changes in allowances and changes in NICE Guidance since 2009, exceeded the recommended ratio of 96 to 98 cases per WTE midwife. A high proportion of community clinics had been cancelled in the 12 months prior to inspection.
- Leaders did not always operate effective governance processes or manage performance effectively. The service did not always collect and collate reliable data; for example, we were not assured NICE red flag data was valid and reliable, and we observed some inaccuracies in other key data we reviewed. The frequency of perinatal morbidity and mortality meetings was not compliant with trust policy, the quality of women's and children's divisional meeting minutes varied, and action plans were not always sufficiently robust.
- The time taken to investigate, and close complaints was not in line with the trust's complaints policy.

However:

- The service provided care and treatment based on national guidance and best practice. Staff completed and updated risk assessments for each woman and took action to remove or minimise risks. Staff identified and quickly acted upon women at risk of deterioration. The service used systems and processes to safely prescribe, administer, record and store medicines.
- The design, maintenance and use of facilities, premises and equipment kept people safe. Staff carried out daily and weekly safety checks of specialist and emergency equipment, and the service controlled infection risk well.
- Staff treated women with compassion and kindness, provided emotional support, respected their privacy and dignity, and took account of their individual needs. Staff supported women to make informed decisions about their care and treatment and followed national guidance to gain patients' consent. Staff understood how to protect women and children from abuse and the service worked well with other agencies to do so.
- The service had an open culture where patients, their families and staff could raise concerns without fear. The service treated concerns and complaints seriously, investigated them and shared lessons learned with staff.

Is the service safe?

Requires improvement   

Our rating of safe stayed the same. We rated it as requires improvement because:

- The service provided mandatory training in key skills to all staff; however, they did not make sure all staff completed it. Completion rates for safeguarding adults' training were low among qualified nursing and midwifery staff.
- Mandatory training compliance rates among medical staff were particularly low; including for life support and resuscitation training. The frequency of 'live' (unannounced) emergency skills and drills training was not compliant with trust policy.
- We saw qualified nurse and midwife sickness rates and use of bank staff were high. Community caseloads, allowing for some changes in allowances and changes in NICE Guidance since 2009, exceeded the recommended ratio of 96 to 98 cases per WTE midwife.
- The use of band three (healthcare assistant) scrub practitioners in theatres was not compliant with national guidance.
- The frequency of perinatal morbidity and mortality meetings was not compliant with trust policy.

However:

Maternity

- Staff kept detailed records of women's care and treatment; and completed and updated risk assessments for each woman and took action to remove or minimise risks. Staff identified and quickly acted upon women at risk of deterioration. The service managed patient safety incidents well.
- Staff understood how to protect women and children from abuse and the service worked well with other agencies to do so.
- The service ensured the proper and safe use of medicines.
- The service controlled infection risk well. They kept equipment and the premises visibly clean.

Is the service effective?

Good   

Our rating of effective stayed the same. We rated it as good because:

- The service provided care and treatment based on national guidance and best practice. Managers checked to make sure staff followed guidance. Staff carried out daily and weekly safety checks of specialist and emergency equipment.
- Staff gave women enough food and drink to meet their needs and improve their health monitored women regularly to see if they were in pain; and gave women practical support and advice to lead healthier lives.
- The service made sure staff were competent for their roles. Managers appraised midwifery and support staff work performance and held supervision meetings with them to provide support and development.
- Staff supported women to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. They knew how to support women who lacked capacity to make their own decisions or were experiencing mental ill health.
- Doctors, nurses and other healthcare professionals worked together as a team to benefit women. They supported each other to provide good care. Key services were available seven days a week to support timely care.

However:

- The total stillbirth rate adjusted to exclude lethal abnormalities, and the stillbirth at term with low birth weight rate, were higher than regional averages.
- The proportion of women smoking at time of booking not a and delivery were higher than trust targets and regional averages.
- Appraisal rates for medical staff and community midwives were low and did not meet trust target.
- Mental Capacity Act training compliance was low and did not meet trust targets.

Is the service caring?

Good   

Our rating of caring stayed the same. We rated it as good because:

- Staff treated women with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

Maternity

- Staff provided emotional support to women, families and carers to minimise their distress. They understood patient's personal, cultural and religious needs.
- Staff supported women, families and carers to understand their condition and make decisions about their care and treatment.

Is the service responsive?

Requires improvement  

Our rating of responsive went down. We rated it as requires improvement because:

- People could not always access the service when they needed it and received the right care promptly; for example, data showed we saw that over 500 clinics had been cancelled in the community over a 12-month period.
- We were not assured treatment delay data (for example, regarding delayed inductions of labour) was always systematically reported and reliable.
- The time taken to investigate, and close complaints was not in line with the trust's complaints policy.

However:

- The service worked with others in the wider system and local organisations to plan care. Waiting times from referral to booking before 13 weeks, and arrangements to assess and monitor women at risk were in line with national standards.
- The service was inclusive and took account of women's individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.
- It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with staff.

Is the service well-led?

Requires improvement  

Our rating of well-led went down. We rated it as requires improvement because:

- Leaders and senior staff had the necessary experience and knowledge to lead effectively. However, there had been some changes within the team. Staff expressed concerns about leadership stability and the implementation of new models of care; and said morale within the service had wavered.
- The service did not have an agreed vision for what it wanted to achieve and the strategy to turn it into action was in draft. In addition, the divisional strategy was in draft form.
- We were not assured leaders always operated effective governance processes. Medical staff reported they were not allocated adequate time for audit, governance and associated activities; and job plan reviews were ongoing to allocate time for these activities. In addition, we found the quality of divisional meeting minutes varied.
- The service did not always collect and collate reliable data; for example, we were not assured NICE red flag data was valid and reliable, and we observed some inaccuracies in other data we reviewed. We were not assured that the service had oversight of clear and reliable midwifery and nurse staffing data.

Maternity

- Staff we spoke with were clear about their roles and accountabilities; but did not always have regular opportunities to meet, discuss and learn from the performance of the service. For example, the frequency of perinatal morbidity and mortality meetings was not compliant.

However:

- Leaders and teams identified and escalated key risks and issues and identified actions to reduce their impact. However, we were not assured that leaders always used systems to manage performance effectively. There were cross-site obstetrics and gynaecology governance meetings, and a lead governance midwife had recently been appointed.
- Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. The service had an open culture where patients, their families and staff could raise concerns without fear. Staff felt respected, supported and valued by colleagues and were focused on the needs of patients receiving care.
- Staff could find most key data they needed, in easily accessible formats, to understand performance, make decisions and improvements. However, leaders recognised improvements in data collection, reliability and accessibility were needed. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.
- Staff were committed to continually learning and improving services; and leaders encouraged innovation and participation in research.

Areas for improvement

We found areas for improvement in this service. See the Areas for Improvement section above.

Services for children and young people

Requires improvement  

Key facts and figures

Children's services at Diana, Princess of Wales Hospital include a 16-bed inpatient ward, with two high observation beds; a paediatric assessment unit, open from 10am until 9/9.30pm every day; a 12-cot neonatal unit and six-cots transitional care ward; a children's outpatient department, a child development centre and a children's community nursing team.

The children's ward admitted children up to the age of 16 years or 18 years for those young people with chronic or complex conditions.

At our last inspection, we rated effective, caring, responsive and well led as good. Safe was rated as requires improvement.

We inspected services for children and young people on 24-27 September 2019 as part of an announced comprehensive inspection of the whole trust due to it being in special measures.

During the inspection visit, the inspection team visited the inpatient ward, the paediatric assessment unit, the neonatal unit, children's outpatients and the child development centre. We spoke with eight parents and their children, 25 members of staff including nursing staff, medical staff, play staff and administration staff. We observed a medical handover and a safety huddle and reviewed 14 sets of records.

Summary of this service

Our rating of this service went down. We rated it as requires improvement because:

- We rated safe and well led as requires improvement. Effective, caring and responsive were rated as good.
- Although the service had addressed some of the concerns from our last inspection, there were still areas where we told the trust they must improve that had not been actioned.
- The service still did not have enough medical or nursing staff to meet national guidance. Nurse staffing on the paediatric assessment unit had not improved.
- The service still did not ensure that young people with mental health concerns were risk assessed and cared for in a suitable environment. Although an assessment tool had been developed, this was not embedded into practice on the children's ward and staff had not completed any mental health training. Environmental risk assessments had been completed, but no action taken.
- We were not assured that the service always controlled infection risk well. Staff on the children's ward did not always use control measures to protect children, young people, their families, themselves, and others from infection.
- The service did not always record and store medicines safely.
- Staff did not always keep detailed records of children and young people's care and treatment.
- Although senior leaders had the skills and abilities to run the service, some ward/ department leaders required a high level of support.
- There was no clear strategy for the service to achieve its vision.

However:

Services for children and young people

- There had been improvements in mandatory training compliance and medical staff had improved their safeguarding level three compliance.
- Staff provided care and treatment in line with national guidance. The service monitored the effectiveness of care and treatment through local and national audits.
- Doctors, nurses and other healthcare professionals worked together as a team to benefit children, young people and their families. They supported each other to provide good care.
- Staff treated children, young people and their families with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.
- People could access the service when they needed it. Waiting times from referral to treatment and arrangements to admit, treat and discharge children and young people were in line with national standards.

Is the service safe?

Requires improvement   

Our rating of safe stayed the same. We rated it as requires improvement because:

- The service still did not have enough nursing or medical staff with the right qualifications, skills, training and experience to meet national guidance. We identified this at our last inspection and told the trust it must ensure they were meeting national standards.
- At our last inspection, in 2018, we told the trust it must ensure that young people with a mental health condition were risk assessed for their mental health needs and cared for in a safe environment that was appropriately risk assessed. At this inspection, we still had concerns that young people with mental health needs were not cared for in a suitable environment and staff had not had any mental health training.
- We were not assured that the service always controlled infection risk well. Staff on the children's ward did not always use control measures to protect children, young people, their families, themselves, and others from infection.
- The service did not always record and store medicines safely.
- Staff did not always keep detailed records of children and young people's care and treatment. Paediatric early warning score (PEWS) and sepsis audits showed several areas of non-compliance.
- There was an abduction policy in place, but not all staff we spoke with were aware of it and it had not been tested. Some staff were unaware of the flagging system to identify children with safeguarding concerns.

However:

- Mandatory training compliance rates had improved since our last inspection. Although there were still some modules with compliance below the trust target.
- Staff understood how to protect children, young people and their families from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse, and they knew how to apply it. Medical staff safeguarding level three training compliance had improved since our last inspection.
- The service managed patient safety incidents well. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave children, young people and their families honest information and suitable support. However, staff we spoke with told us they did not always have time to report incidents.

Services for children and young people

Is the service effective?

Good  → ←

Our rating of effective stayed the same. We rated it as good because:

- The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance.
- Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for children and young people, demonstrated in national audits.
- Staff gave children and young people enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. The service made adjustments for children, young people and their families' religious, cultural and other needs.
- The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development.
- Doctors, nurses and other healthcare professionals worked together as a team to benefit children, young people and their families. They supported each other to provide good care.
- Staff supported children, young people and their families to make informed decisions about their care and treatment.

However:

- Local audits of paediatric early warning scores (PEWS) and sepsis had provided limited assurance due to lack of improvement in several standards and levels of compliance not being in line with national standards. Action plans had been developed to address recommendations.
- Although staff assessed and monitored children and young people regularly to see if they were in pain, pain relief was not always given in a timely way.
- Staff were not meeting targets for compliance with mental capacity act training or appraisal completion.

Is the service caring?

Good  → ←

Our rating of caring stayed the same. We rated it as good because:

- Staff treated children, young people and their families with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.
- Friends and family test responses were consistently positive.
- Staff provided emotional support to children, young people and their families to minimise their distress. They understood children and young people's personal, cultural and religious needs.
- Staff supported and involved children, young people and their families to understand their condition and make decisions about their care and treatment. They ensured a family centred approach.

Services for children and young people

Is the service responsive?

Good ● → ←

Our rating of responsive stayed the same. We rated it as good because:

- The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.
- The service had worked with the local CCG on a service specification to develop a transanal irrigation service, as there was no robust continence service.
- The service was inclusive and took account of children, young people and their families' individual needs and preferences. Staff made reasonable adjustments to help children, young people and their families access services. They coordinated care with other services and providers.
- People could access the service when they needed it. Waiting times from referral to treatment and arrangements to admit, treat and discharge children and young people were in line with national standards.
- It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff.

However:

- At our last inspection, in 2018, children's services were not meeting the Accessible Information Standards (2017), as parents and carers communication support needs were not routinely identified. At this inspection, we saw there were posters on the walls explaining what the accessible information standard was, but staff were still not routinely asking and recording this information.
- There were significant delays to resolution of complaints.
- Not all children on the children's ward were seen by a consultant within 14 hours, in line with national guidance.

Is the service well-led?

Requires improvement ● ↓

Our rating of well-led went down. We rated it as requires improvement because:

- There has been a lack of pace to address the actions that we told the trust it must take to improve the concerns found following our last inspection, in 2018, had not been fully completed. Medical and nurse staffing were still not compliant with national guidance. Staff we spoke with told us there had been several business cases submitted for increased staffing over the last year. We were not assured children and young people with a mental health condition were risk assessed for their mental health needs, self-harm or suicide and that they were cared for in a safe environment that was appropriately risk assessed. Staff had still not received mental health training in caring for children and young people with mental health needs.
- Job plans for medical staff were out of date.
- We found the quality of women's and children's divisional meeting minutes varied, and it was sometimes unclear as to when meetings had occurred and who had attended.

Services for children and young people

- Some ward/department leaders required high levels of support and members of the executive team were not always visible.
- Although the service had a vision for what it wanted to achieve, it had no clear strategy.

However:

- Staff felt respected, supported and valued. They were focused on the needs of patients receiving care.

Areas for improvement

We found areas for improvement in this service. See the Areas for Improvement section above

End of life care

Inadequate ● ↓

Key facts and figures

End of life (EOL) care encompasses all care given to patients who are approaching the end of their life and following death. It may be given on any ward or within any service in a trust. It includes aspects of essential nursing care, specialist palliative care, bereavement support and mortuary services. EOL care is provided across the organisation by ward nurses, health care assistants, mortuary, bereavement and clerical staff across all directorates 365 days per year. Ward staff are supported by an acute specialist Macmillan nurse who usually assisted staff to deliver end of life care across acute settings, through education, training, assessment and clinical availability however this post was vacant at the time of inspection. A clinical practice educator provided support across both acute hospitals.

At our last inspection, we rated safe, effective, responsive and well led as requires improvement and caring as good.

We inspected end of life and palliative care services on 24-27 September 2019 as part of an announced comprehensive inspection of the whole trust due to it being in special measures. We carried out a further unannounced visit on the 10th October.

As part of our inspection we observed daily practice and viewed 16 sets of patient records and 'do not attempt cardiopulmonary resuscitation' (DNACPR) records and eight prescription charts. During the inspection we visited surgical, medical and care of the elderly wards, and also visited the mortuary, hospital chapel and bereavement team. We spoke to patients who were receiving end of life care and patients' relatives.

We spoke with 25 members of staff across general wards, which included medical and nursing staff, the specialist palliative care team, the leadership team for end of life care, chaplaincy, mortuary and bereavement staff.

Summary of this service

Our rating of this service went down. We rated it as inadequate because:

- The service had not addressed many of the concerns from our last inspection, there were still areas where we told the trust they must improve that had not been actioned.
- At the last inspection in 2018 we told the trust it must ensure that sufficient numbers of palliative care staff are employed to provide care and treatment. At this inspection the service still did not have enough nursing or medical staff with the right qualifications, skills, training and experience to meet national guidance. Managers did not regularly review and adjust staffing levels and skill mix.
- The service did not have enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and provide the right care and treatment.
- Staff did not always keep detailed records of patients' care and treatment. Records were not consistently clear and up-to-date or easily available to all staff providing care.
- The service provided mandatory training in key skills however they did not ensure all staff had completed it.
- The service did not always provide care and treatment based on national guidance and evidence-based practice.
- There was very limited monitoring of patients care and treatment. Therefore, staff did not always monitor the effectiveness of care and treatment or use the findings to make improvements and achieve good outcomes for patients.

End of life care

- Preferred place of death was not consistently documented for all patients receiving end of life care.
- Staff did not consistently assess and monitor patients regularly to see if they were in pain and did not give pain relief in a timely way. Staff did not always complete documentation specific to end of life and palliative care.
- Staff did not support those unable to communicate using suitable assessment tools and give additional pain relief to ease pain.
- The service did not make sure staff were competent for their roles. Managers did not appraise staff's work performance and or hold supervision meetings with them to provide support and development.
- At the last inspection in 2018 we saw the trust was not providing a seven-day service. Key services were still not available seven days a week to support timely patient care.
- Staff did not consistently treat patients with compassion and kindness. Individuals privacy, dignity and their individual needs were not always taken in to account.
- Staff did not always support and involve patients, families and carers to understand their condition and make decisions about their care and treatment.
- The service did not always take account of patients' individual needs and preferences. Multi faith facilities were not fully in place and access to chaplains was limited.
- The service did not consistently monitor performance to enable improvements for people at the end of their life. This included rapid discharge arrangements to enable people to meet their preferred place of care and death and referral to treatment times
- There had been no improvement in the complaint's management for the service.
- There were insufficient leaders with the skills and abilities to run the service. They did not understand or manage the priorities and issues the service faced. Due to the small numbers of staff their visibility was limited. There was no clear leadership of the service and lines of accountability were blurred.
- Key senior management staff roles had been vacant for some time and remained unfilled at the time of inspection.
- There was no current local strategy or vision for the service.
- Staff working within the service told us they did not feel valued and respected. There was no sense that staff were fully engaged in making dying everyone's responsibility.
- There was a lack of governance structures in place with processes and systems of accountability to support a sustainable service.
- There was little understanding or management of risk. There was no risk register to identify that there was oversight of the current risks or that these had been escalated. For example, the lack of audit completion and staff vacancies. Therefore, risks were not shared within this speciality
- Leaders and staff undertook limited engagement with patients and staff to plan and manage services.
- We saw limited evidence of any information to support learning, continuous improvement or innovation in the service.

However:

- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. There had been improvements in medical staff safeguarding training compliance.

End of life care

- Systems had been introduced since the last inspection to improve systems within the mortuary such as cleaning and fridge temperature monitoring.

Is the service safe?

Requires improvement   

Our rating of safe stayed the same. We rated it as requires improvement because:

- At the last inspection in 2018 we told the trust it must ensure that sufficient numbers of palliative care staff are employed to provide care and treatment.
- At the last inspection in 2018 we told the trust it must ensure that sufficient numbers of palliative care staff are employed to provide care and treatment. At this inspection the service still did not have enough nursing with the right qualifications, skills, training and experience to meet national guidance. Managers did not regularly review and adjust staffing levels and skill mix.
- The service did not have enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and provide the right care and treatment.
- The design of the mortuary did not always keep people safe.
- At the last inspection in 2018, the trust were told they must ensure that all patient records are completed fully. At this inspection we saw staff did not keep detailed records of patients' care and treatment. Records were not consistently clear and up to date up-to-date or easily available to all staff providing care.
- Staff did not consistently review patients' medicines.
- We did not see any written evidence of learning from incidents, changes in practice or wider dissemination across the whole specialty as a result.

However:

- The service provided mandatory training in key skills and ensured all staff had completed it.
- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

Is the service effective?

Inadequate  

Our rating of effective went down. We rated it as inadequate because:

- The service did not always provide care and treatment based on national guidance and evidence-based practice.
- Staff did not consistently assess and monitor patients regularly to see if they were in pain and did not give pain relief in a timely way.
- Preferred place of death was not consistently documented for all patients receiving end of life care.
- Staff did not support those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.

End of life care

- The service did not make sure staff were competent for their roles. Managers did not hold supervision meetings to provide support and development.
- At the last inspection in 2018 we saw the trust was not providing a seven-day service. Key services were still not available seven days a week to support timely patient care.

However:

- Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary.
- Staff gave patients practical support to help them live well until they died.

Is the service caring?

Requires improvement  

Our rating of effective went down. We rated it as requires improvement because:

- Staff did not consistently treat patients with compassion and kindness.
- They did not always respect patient's privacy and dignity or take their individual needs in to account.
- Staff did not always provide emotional support to patients, families and carers to minimise their distress.
- Staff did not always support and involve patients, families and carers to understand their condition and make decisions about their care and treatment.

However:

- Two patients who were being cared for on a general ward with oversight from the palliative care team told us that the team and the ward staff had been caring and had involved the patient's family.

Is the service responsive?

Requires improvement  

Our rating of effective stayed the same. We rated it as requires improvement because:

- The service undertook limited planning of care with regards the needs of local people and the communities served.
- The service did not always take account of patients' individual needs and preferences. Multi faith facilities were not fully in place and access to chaplains was limited.
- The trust did not consistently monitor performance to enable improvements for people at the end of their life. This included rapid discharge arrangements to enable people to meet their preferred place of care and death and referral to treatment times.
- There had been no improvement in the trust's complaints management. Complaints were not managed in accordance with trust policy or shared with colleagues to drive improvement.
- Information leaflets regarding death and bereavement were only available in English.

However:

End of life care

- Equipment loan services were available seven days a week, with community equipment loans accessible to ward staff.
- Bereavement staff at SGH offered a one stop shop arrangements for families visiting to collect death certificates.

Is the service well-led?

Inadequate ● ↓

Our rating of well-led went down. We rated it as inadequate because:

- There were insufficient leaders with the skills and abilities to run the service. They did not understand or manage the priorities and issues the service faced. Due to the small numbers of staff their visibility was limited. There was no clear leadership of the service and lines of accountability were blurred.
- Actions we told the trust it must take to address concerns following our last inspection, in 2018, had not been completed.
- Key senior management staff roles had been vacant for some time and remained unfilled at the time of inspection.
- There was no current local strategy or vision for the service.
- Staff working within the service told us they did not feel valued and respected. There was no sense that staff were fully engaged in making dying everyone's responsibility.
- There was a lack of governance structures in place with processes and systems of accountability to support a sustainable service.
- Managers of the service did not always complete internal audits. Those which were completed were not progressed through the monitoring of effective action plans.
- There was little understanding or management of risk. There was no risk register to identify that there was oversight of the current risks or that these had been escalated. For example, the lack of audit completion and staff vacancies. Therefore, risks were not shared within this speciality
- Leaders and staff undertook limited engagement with patients and staff to plan and manage services.
- We saw limited evidence of any information to support learning, continuous improvement or innovation in the service.

However:

- Staff held the palliative care consultant in high regard and felt the service sustainability was due to this individual's dedication.

Areas for improvement

We found areas for improvement in this service. See the Areas for Improvement section above.

Outpatients

Inadequate   

Key facts and figures

Outpatient services are provided on all three hospital sites in dedicated outpatient areas. There are a number of out-reach clinics that take place outside of the main hospital sites. The majority of clinics are provided during core hours; however, a small number of evening and weekend clinics take place.

Outpatients and pathology were part of the clinical support services division. Clinical Support Services Division role is to provide nursing staff, administration support for receptions and all of the health records functionality. A range of clinics were provided by outpatients such as surgery outpatients, medicine outpatients, ophthalmology, respiratory, diabetes, urology, neurology and ear, nose and throat.

Waiting lists for each speciality were held by that speciality. The method of delivery is predominantly face to face, however, the trust were beginning to review some patients via telephone clinics.

We visited the Diana, Princess of Wales Hospital outpatients department at the trust during the inspection. The services were previously inspected in May 2018 and were rated overall as inadequate.

Our inspection was announced (staff knew we were coming) to enable us to observe routine activity.

During the inspection we spoke with 25 staff, 12 patients and reviewed 16 records.

Total number of first and follow up attendances compared to England

The trust had 374,436 first and follow up outpatient attendances from March 2018 to February 2019.

(Source: Hospital Episode Statistics - HES Outpatients)

Number of appointments by site (including DNAs and cancellations)

The following shows the number of outpatient appointments by site, a total for the trust and the total for England, from March 2018 to February 2019.

Diana, Princess of Wales Hospital - 213,297

Scunthorpe General Hospital - 159,590

Goole and District Hospital - 1,725

This trust - 404,612

England total- 109,330,519

(Source: Hospital Episode Statistics)

Summary of this service

Our rating of this service stayed the same. We rated it as inadequate because:

- The trust had identified incidents in 2018 and 2019 where patients had come to harm due to delays in receiving appointments in out-patients. We had significant concerns regarding this and requested further information from the

Outpatients

trust on what it was doing to limit risk in a section 31 “letter of intent to seek further clarification from the trust”. The trust provided a response to this. CQC continue to have concerns about the risks of harm and potential harm to patients when waiting times remain lengthy. However, we were assured that the trust had put in place oversight mechanisms and processes to limit the risks.

- Following the inspection, the trust provided more information which showed they had revised the inclusion criteria for patients to be added to the clinical harm review in ophthalmology to include any delay that exceeded the speciality/department risk stratification criteria. For example, in September 2019, this new risk stratification criteria had identified 83 patients to be added to the clinical harm review. Of these 83 patients, 37 patients had been seen and assessed for harm and the trust highlighted there was no harm in 24 of these patients, there was low harm in ten patients and one moderate harm and two severe harm. Out of the 83 patients identified, the remaining 46 patients were due to have a clinical harm review in November 2019.
- Whilst the trust had implemented clinical validation to help ensure patients were seen in order of clinical need, there remained risk in some waiting lists due to the volume of patients on the waiting list and the service not meeting the operational standard for patients receiving their first treatment within 62 days of an urgent GP referral for a suspected cancer diagnosis. This was an ongoing concern since our previous inspection. The trust provided information after the inspection stating they were taking steps to address the challenges with cancer performance in accordance with the trust’s performance management framework.
- We did not see evidence of safety checklists being used in any areas other than in ophthalmology.
- Staff did not consistently tell us they had received shared learning from incidents.
- Although records were now stored securely, which was an improvement since our last inspection, records were not always timed or signed by staff, and staff did not always provide their role or designation. Written notes were not consistently legible. These concerns were ongoing since our previous inspection.
- Although the oversight of waiting lists and backlogs had improved, the July 2019 board papers showed there remained 33,673 overdue outpatient review appointments in May 2019. Overall there had been improvements with the referral to treatment indicators, however there remained specialties which did not always achieve the referral to treatment indicators.
- From June 2018 to May 2019 the trust’s referral to treatment time (RTT) for non-admitted pathways has been worse than the England overall performance. The latest figures for May 2019, showed 78.7% of this group of patients were treated within 18 weeks versus the England average of 87.6%.
- From June 2018 to May 2019 the trust’s referral to treatment time (RTT) for incomplete pathways has been worse the England overall performance, although there has been an improving trend from January to May 2019. The latest figures for May 2019 showed 77.8% of patients still waiting for treatment had been waiting for less than 18 weeks, versus the England average of 86.4%.
- From June 2018 to June 2019, the trust received 134 complaints in relation to outpatients at the trust (27.6% of total complaints received by the trust). 66 complaints were still open and under investigation or partially upheld with no closed date. Of the 68 complaints that were closed, the trust took an average of 82.2 working days to investigate and close complaints. This was not in line with their complaints policy, which states complaints should be closed within 60 working days.
- From March 2018 to February 2019, the ‘did not attend’ rate for Diana, Princess of Wales Hospital was higher (worse) than the England average.

Outpatients

- Leaders were not always visible in the outpatient department. Staff did not always feel respected, supported and valued. At the previous inspection, there was no strategy in place and although the trust had developed a strategy and provided the draft strategy for outpatients, this was still a draft version.

However, we also found:

- The service provided mandatory training in key skills to all staff and made sure everyone completed it. Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.
- The service controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean. Staff managed clinical waste well.
- The service had enough nursing and support staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed staffing levels and skill mix and gave bank staff a full induction. The service used systems and processes to safely prescribe, administer, record and store medicines.
- Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care. Staff gave patients practical support and advice to lead healthier lives. Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs. Staff provided emotional support to patients, families and carers to minimise their distress. Patients were given contact details for specialist nurses to contact with any worries or questions.
- Staff supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment. Patients we spoke with gave positive feedback about their care and treatment in outpatients at this hospital.
- The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. Leaders and teams used systems to manage performance.
- There had been improvement in some areas and improved oversight and governance regarding the challenges across outpatient services. The services had implemented procedures to support the work regarding the challenges in outpatients, for example outpatient leaders monitored performance through performance reports and regular meetings.

Is the service safe?

Inadequate ● ↓

Our rating of safe went down. We rated it as inadequate because:

- The trust had identified incidents in 2018 and 2019 where patients had come to harm due to delays in receiving appointments in out-patients. We had significant concerns regarding this and requested further information from the trust on what it was doing to limit risk in a section 31 "letter of intent to seek further clarification from the trust". The trust provided a response to this. CQC continue to have concerns about the risks of harm and potential harm to patients when waiting times remain lengthy. However, we were assured that the trust had put in place oversight mechanisms and processes to limit the risks.

Outpatients

- After the inspection, the trust told us they had revised the inclusion criteria for patients to be added to the clinical harm review in ophthalmology to include any delay that exceeded the speciality/department risk stratification criteria. For example, in September 2019, this new risk stratification criteria had identified 83 patients to be added to the clinical harm review. Of these 83 patients, 37 patients had been seen and assessed for harm and the trust highlighted there was no harm in 24 of these patients, there was low harm in ten patients and one moderate harm and two severe harm. Out of the 83 patients identified, the remaining 46 patients were due to have a clinical harm review in November 2019.
- Whilst the trust had implemented clinical validation to help ensure patients were seen in order of clinical need, there remained significant risk in some waiting lists due to the volume of patients on the waiting list and the service not meeting the operational standard for patients receiving their first treatment within 62 days of an urgent GP referral for a suspected cancer diagnosis. This was an ongoing concern since our previous inspection.
- Although the trust provided examples of learning from incidents, staff did not consistently tell us they had received shared learning from incidents. We did not receive any evidence that learning from incidents was shared throughout the outpatients department.
- We did not see evidence of safety checklists being used in any areas other than in ophthalmology.
- Although records were now stored securely, which was an improvement since our last inspection, records were not always timed or signed by staff, and staff did not always provide their role or designation. Written notes were not consistently legible. These concerns were ongoing since our previous inspection.

However:

- The service provided mandatory training in key skills to all staff and made sure everyone completed it. Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.
- The service controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean. Staff managed clinical waste well.
- The service had enough nursing and support staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed staffing levels and skill mix and gave bank staff a full induction. The service used systems and processes to safely prescribe, administer, record and store medicines.

Is the service effective?

Not sufficient evidence to rate



We do not rate effective in outpatients, however we found:

- The service provided care and treatment based on national guidance and evidence of its effectiveness. Managers checked to make sure staff followed guidance.
- Staff gave patients enough food and drink to meet their needs and improve their health.
- Staff monitored the effectiveness of care and treatment.
- The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development.

Outpatients

- Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.
- Staff gave patients practical support and advice to lead healthier lives.
- Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent.

Is the service caring?

Good ● ➡ ➡

Our rating of caring stayed the same. We rated it as good because:

- Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.
- Staff provided emotional support to patients, families and carers to minimise their distress. Patients were given contact details for specialist nurses to contact with any worries or questions.
- Staff supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment.
- All of the patients we spoke with gave positive feedback about their care and treatment in outpatients at this hospital.
- In August 2019, 94% of people who completed the Friends and Family Test (FFT) were extremely likely or likely to recommend this outpatients department to their family and friends.

Is the service responsive?

Inadequate ● ➡ ➡

Our rating of responsive stayed the same. We rated it as inadequate because:

- Although the oversight of waiting lists and backlogs had improved, the July 2019 board papers showed there remained 33,673 overdue outpatient review appointments in May 2019.
- There remained challenges with the services meeting the 62-day cancer waiting time targets. The trust was performing worse than the 85% operational standard for patients receiving their first treatment within 62 days of an urgent GP referral. This was an issue at the previous inspection. The trust provided further information stating that they were aware of the need to improve and had taken additional actions to address this such as bringing in external clinical expertise to work alongside clinicians to change and improve decision making.
- Overall referral treatment times had improved in some specialities since our May 2018 inspection. The trust also provided some information which showed a reduction in patients waiting more than 40+ weeks from 1503 to 311, however there remained challenges within some specialities.
- From June 2018 to May 2019 the trust's referral to treatment time (RTT) for non-admitted pathways has been worse than the England overall performance. The latest figures for May 2019, showed 78.7% of this group of patients were treated within 18 weeks versus the England average of 87.6%.

Outpatients

- From June 2018 to May 2019 the trust's referral to treatment time (RTT) for incomplete pathways has been worse than the England overall performance, although there has been an improving trend from January to May 2019. The latest figures for May 2019 showed 77.8% of patients still waiting for treatment had been waiting for less than 18 weeks, versus the England average of 86.4%.
- From June 2018 to June 2019, the trust received 134 complaints in relation to outpatients at the trust (27.6% of total complaints received by the trust). 66 complaints were still open and under investigation or partially upheld with no closed date. Of the 68 complaints that were closed, the trust took an average of 82.2 working days to investigate and close complaints. This was not in line with their complaints policy, which states complaints should be closed within 60 working days.
- From March 2018 to February 2019, the 'did not attend' rate for Diana, Princess of Wales Hospital was higher (worse) than the England average.

However:

- The service worked with others in the wider system and local organisations to plan care.
- The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services.
- The trust was performing better than the 93% operational standard for people being seen within two weeks of an urgent GP referral.
- The trust was performing better than the 96% operational standard for patients waiting less than 31 days before receiving their first treatment following a diagnosis (decision to treat).

Is the service well-led?

Requires improvement  

Our rating of well-led improved. We rated it as requires improvement because:

- Although there had been improvements in the governance and oversight of waiting lists and backlogs. There remained challenges with the backlog of overdue patients waiting for appointments, referral to treatment indicators and the 62-day cancer waiting times remained a challenge. The trust provided information after the inspection stating they were taking steps to address the challenges with cancer performance in accordance with the trust's performance management framework.
- There had been incidents of patient harm which related to the delay in treatment across the specialties, for example in ophthalmology outpatients.
- At the previous inspection, there was no strategy in place and although the trust had developed a strategy and provided the draft strategy for outpatients, this was still a draft version.
- Leaders were not always visible in the outpatient department and staff did not always feel respected, supported and valued across the outpatient department.
- There was limited evidence of innovation across the outpatient departments.

However:

- The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. Leaders and teams used systems to manage performance.

Outpatients

- There had been improvement in some areas and improved oversight and governance regarding the challenges across outpatient services. The services had implemented procedures to support the work regarding the challenges in outpatients, for example outpatient leaders monitored performance through performance reports and regular meetings.
- The service collected data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Leaders and staff actively and openly engaged with patients.

Areas for improvement

We found areas for improvement in this service. See the Areas for Improvement section above.

Diagnostic imaging

Inadequate ● ↓

Key facts and figures

Radiology is provided across the three main sites: DPoW site provides X-ray, fluoroscopy, CT, MRI, ultrasound, breast imaging and nuclear medicine services; SGH provides X-ray, fluoroscopy, CT, MRI and ultrasound; and Goole and District Hospital provides X-ray, fluoroscopy, and ultrasound with some mobile CT & MRI provision at this site.

Most services are provided across seven days, the exceptions being breast imaging and nuclear medicine which are five-day services. Emergency services are provided 24/7 for X-ray and CT at the two main sites. There is some community ultrasound provision, in GP surgeries across the region.

Audiology services are provided from all three hospital sites, as well as in many community settings. Physiological measurement investigations are undertaken on the two main hospital sites by a team based at DPoW.

(Source: Routine Provider Information Request (RPIR) – AC1. Context acute)

Summary of this service

Our rating of this service went down. We rated it as inadequate because:

- Patients could not always access the service when they needed it. Waiting and result reporting times were not in line with national standards.
- There had been incidents where patients had come to harm due to delays in reporting results. We had significant concerns regarding this and after the inspection, the Care Quality Commission completed a section 31 letter of intent to seek further clarification from the trust.
- Safety was not a sufficient priority. Although there was measurement and monitoring of safety performance, there was a limited response leading to unacceptable levels of incidents and potential harm.
- There had been a lack of pace to address the backlogs and therefore there were concerns that incidents and near misses were not recognised which had caused harm and put patients at risk of harm or potential harm.
- Safety was not a sufficient priority. Although there was measurement and monitoring of safety performance, there was a limited response leading to unacceptable levels of incidents and potential harm.
- From May 2018 to April 2019, the percentage of patients waiting more than six weeks to see a clinician (12%) was higher than the England average (3%).
- Substantial, ongoing and frequent staff shortages increased risks to people who used services.
- Although, the trust had systems for identifying risks in place, opportunities to prevent and minimise harm were missed.
- Since our last inspection in 2018, the backlog in unreported results had increased from 5,364 examinations (3,686 patients) to 10,701 examinations (7,045 patients) in July 2019.
- The contract with the external reporting company to address the backlog had been put in place in August 2019. This delay increased the potential risk of harm to patients.
- At the time of inspection, the overall backlog in unreported results across all modalities was 7,942 delays (4,719 patients).

Diagnostic imaging

- Following inspection, the initial trajectory for clearing the backlog in unreported results had changed and extended, increasing the risk of potential and actual harm to patients still within the backlog of unreported and delayed results.
- There were trust wide shortages of radiologists. This impacted on reporting rates across the trust, including Diana, Princess of Wales Hospital.
- Although there was some resistance from existing radiologists to supporting the long-term development of radiographers' capacity to report on results, the expansion of plain film reporting to chest and abdomen was supported and the trust had also put in place other initiatives to improve their reporting capacity.
- From June 2018 to June 2019, the trust received 19 complaints in relation to diagnostic imaging (3.9% of total complaints received by the trust). Nine complaints were still open and under investigation or partially upheld with no closed date. Of the closed complaints, the trust took an average of 67.8 working days to investigate and close. This was not in line with their complaints policy, which states complaints should be completed within 60 working days.
- There was inconsistency of record keeping at the hospital. Of the records we checked over half were missing key documents such as recording of consent to treatment.
- A finalised divisional strategy was not in place and had been developed to draft stage only.

However:

- The service provided mandatory training in key skills to all staff and made sure everyone completed it.
- The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use equipment.
- Staff we spoke with were aware of their responsibilities in relation to duty of candour.
- The service provided care and treatment based on national guidance and evidence of its effectiveness. Managers checked to make sure staff followed guidance.
- Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.
- In August 2019, 80% of people who completed the Friends and Family Test (FFT) were extremely likely or likely to recommend this service to their family and friends.
- The service planned and provided care in a way that met the needs of local people and the communities served.
- The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services.

Is the service safe?

Inadequate ● ↓

Our rating of safe went down. We rated it as inadequate because:

- At the time of inspection, the overall backlog in unreported results across all modalities was 7,942 delays (4,719 patients).

Diagnostic imaging

- Following inspection, the initial trajectory for clearing the backlog in unreported results had changed and extended, increasing the risk of potential and actual harm to patients still within the backlog of unreported and delayed results.
- There had been incidents where patients had come to harm, due to delays in tests and reporting of results. We had significant concerns regarding this and after the inspection, the Care Quality Commission completed a section 31 letter of intent to seek further clarification from the trust.
- There had been a lack of pace to address the backlogs and therefore there were concerns that incidents and near misses were not recognised which had caused harm and put patients at risk of harm or potential harm.
- Safety was not a sufficient priority. Although there was measurement and monitoring of safety performance, there was a limited response leading to unacceptable levels of incidents and potential harm.
- There was insufficient numbers of medical staff.

There were trust wide shortages of radiologists. This impacted on reporting rates across the trust, including Scunthorpe General Hospital.

- There were inconsistencies within the electronic records we reviewed. Of the records we checked over half were missing key documents such as recording of consent to treatment.

However, we also found:

- The service provided mandatory training in key skills to all staff and made sure everyone completed it.
- The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use equipment.
- Local rules were clear as to which procedures could be requested by individual clinicians.
- Staff we spoke with were aware of their responsibilities in relation to duty of candour.

Is the service effective?

Not sufficient evidence to rate ●

We do not rate effective in diagnostic imaging, however we found:

- The service provided care and treatment based on national guidance and evidence of its effectiveness. Managers checked to make sure staff followed guidance.
- Staff monitored the effectiveness of care and treatment.
- Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.
- Staff gave patients practical support and advice to lead healthier lives.
- The service made sure staff were competent for their roles.

However:

- Managers had not appraised staff's work performance in line with trust targets.

Diagnostic imaging

Is the service caring?

Good ● → ←

Our rating of caring stayed the same. We rated it as good because:

- Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.
- Staff provided emotional support to patients, families and carers to minimise their distress.
- Staff supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment.
- All patients gave positive feedback about their care and treatment in outpatients at this hospital.
- In August 2019, 86% of people who completed the Friends and Family Test (FFT) were extremely likely or likely to recommend this service to their family and friends.

Is the service responsive?

Inadequate ● ↓

Our rating of responsive went down. We rated it as inadequate because:

- The service did not provide care in a way that met the needs of local people and the communities served. However the department was accessible.
- Patients could not always access the service when they needed it. Waiting and result reporting times were not in line with national standards.
- From May 2018 to April 2019, the percentage of patients waiting more than six weeks to see a clinician (12%) was higher than the England average (3%).
- Substantial, ongoing and frequent staff shortages increased risks to people who used services.
- Since our last inspection in 2018, the backlog in unreported results had increased from 5364 examinations (3686 patients) to 10701 examinations (7045 patients) in July 2019.
- The contract with the external reporting company to address the backlog had been put in place in August 2019. This delay increased the potential risk of harm to patients.
- Following inspection, the initial trajectory for clearing the backlog in unreported results had changed and extended, increasing the risk of potential and actual harm to patients still within the backlog of unreported and delayed results.
- From June 2018 to June 2019, the trust received 19 complaints in relation to diagnostic imaging (3.9% of total complaints received by the trust). Nine complaints were still open and under investigation or partially upheld with no closed date. Of the closed complaints, the trust took an average of 67.8 working days to investigate and close. This was not in line with their complaints policy, which states complaints should be completed within 60 working days.

However:

- The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services.

Diagnostic imaging

- The trust were taking actions to address the backlogs and had reduced these by 47% by November 2019.

Is the service well-led?

Requires improvement ● ➡ ➡

Our rating of well-led stayed the same. We rated it as requires improvement because:

- At the time of inspection, the overall backlog was 7,942 delays in reporting results affecting 4,719 patients.
- Although there was a governance structure in place monitoring waiting lists for treatments and delays in reporting results, the delay in finalising the contract with the external reporting company had increased the potential risk of harm to patients.
- Although we saw evidence that the trust was actively assessing and monitoring risks to patients, we were not assured that these were managed in a timely way to prevent or minimise harm.
- Although, the trust had systems for identifying risks in place, opportunities to prevent and minimise harm were missed.
- At the previous inspection, a strategy was not in place and although the division had developed a strategy, this had not been finalised.
- Although there was some resistance from existing radiologists to supporting the long-term development of radiographers' capacity to report on results, the expansion of plain film reporting to chest and abdomen was supported and the Trust had also put in place other initiatives to improve their reporting capacity

However:

- Leaders and staff engaged with patients and most staff felt respected, supported and valued.

Areas for improvement

We found areas for improvement in this service. See the Areas for Improvement section above.

Scunthorpe General Hospital

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Scunthorpe
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Key facts and figures

Scunthorpe General Hospital (SGH) is one of the three hospital sites for Northern Lincolnshire and Goole NHS Foundation Trust. It is located in Scunthorpe and provides acute hospital services to the local population.

SGH is the trust's second largest hospital. It offers a range of inpatient and outpatient services including urgent and emergency care, medical care, surgery, critical care, maternity, end of life and outpatients and diagnostic services for children, young people and adults primarily in the North Lincolnshire area.

The CQC has carried out a number of inspections of the trust; the last comprehensive inspection of the acute services was in 8-11 May 2018 with an unannounced focused inspection carried out on 23 May 2018. The report was published in September 2018 and overall the trust was rated as requires improvement with safe, effective and responsive being rated as requires improvement and caring rated as good.

We carried out a comprehensive inspection of urgent and emergency care, medicine, surgery, critical care, maternity, services for children and young people, outpatients and diagnostic imaging from 24 to 27 September 2019. We carried out an unannounced inspection on the 10 October 2019.

At the time of inspection Scunthorpe General Hospital had approximately 400 inpatient beds. In addition, the hospital provides critical care services, with eight beds available for intensive care and high dependency, close to the main theatre complex.

The trust services are commissioned by the following Clinical Commissioning Groups (CCG's), who commission the majority of the trust's services, and also local authorities.

- Northern East Lincolnshire CCG.
- North and North East Lincolnshire CCG.
- East Riding of Yorkshire CCG.
- North East Lincolnshire council.

Summary of services at Scunthorpe General Hospital

Requires improvement   

Our rating of services stayed the same. We rated it them as requires improvement because:

Summary of findings

- There had been little progress identified in this inspection and in some services a deterioration.
- Within outpatients continued backlogs were identified and within diagnostic imaging there was also an increased backlog of patient awaiting diagnostic image services and the subsequent reporting of x-rays. There were unknown risks due to these backlogs.
- There had been incidents where patients had come to harm due to delays in receiving appointments in both outpatients and diagnostic imaging. We had concerns regarding this and after the inspection, the Care Quality Commission completed a section 31 letter of intent to seek further clarification from the trust.
- Within end of life we were concerned about the timeliness of pain relief given to patients and lack of documentation which would enable to trust to monitor the effectiveness of care and treatment and drive improvement.
- Across most services there was still insufficient numbers of staff within the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment.
- The service provided mandatory training in key skills to staff but had not ensured everyone had completed it. Across most services there were continued low levels of mandatory training.
- We had ongoing concerns that patients with mental health conditions were not always cared for in a safe environment.
- Within the emergency department there were significant numbers of black breaches and the department failed to meet the medium time to initial assessment.
- The services did not always provide care and treatment in line with national guidance and best practice. We found examples of this in some of the core services inspected.
- The services did not ensure that staff were competent to carry out their roles and compliance with annual appraisals continued to be low.
- Services were not always planned to meet the needs of local services. This was particularly so in end of life services.
- Waiting times, referral to treatment and arrangements to admit, treat and discharge across a number of core services continued to be a challenge. People could not always access the services when they needed to.
- Investigations of complaints were not managed in a timely way and in line with trust policy.
- Across most services there continued to be a lack of clear strategies at this level.
- Systems to manage performance were not consistently used to improve performance.
- There continued to be changes in the governance structures and processes which had not become embedded and therefore there was limited oversight.
- There was limited evidence of continuous improvement and innovation across most core services.

However:

- Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.
- Overall staff felt respected, supported and valued.
- Most services had an open culture where patients, their families and staff could raise concerns without fear.

Urgent and emergency services

Requires improvement   

Key facts and figures

The trust provides trauma units at its Diana, Princess of Wales Hospital (DPOW) and Scunthorpe General Hospital (SGH) Emergency Care Centres (ECCs) who are part of the Yorkshire and Humber region. Adult major trauma is provided for at Hull Royal Infirmary whilst paediatric major trauma is provided for at Sheffield Children's Hospital.

SGH provides hyper acute stroke services for the trust. ECCs are consultant led with consultants available either directly on the shop floor or on call out of hours.

Cover for gastrointestinal (GI) bleeds is currently provided on both sites. DPOW and SGH have acute medical units led by acute care physicians from 08:30 to 17:00 Monday to Friday. Outside of these hours an on call physician provides consultant presence. Consultant cover weekends is 08:00 to 20:00, then cover as on call.

SGH has an ambulatory emergency care (AEC) facility led by the advanced level practitioners (ACPs) and a frail and elderly assessment support team (FEAST) providing comprehensive geriatric assessment (CGA) for frail older people coming through the "front door".

The inspection was announced (staff knew we were coming), at this inspection we inspected and rated all key questions (Safe, Effective, Caring, Responsive and Well led). During the inspection of the emergency department at Scunthorpe Hospital we spoke with 16 staff, 17 patients, 16 relatives and reviewed 10 patient records.

Summary of this service

Our rating of this service stayed the same. We rated it as requires improvement because:

- At the previous inspection we found that the department did not meet the trust standard for completion of mandatory training. At this inspection the department still did not meet the mandatory training standards.
- At the previous inspection we found that not all staff had a completed up to date appraisal. At this inspection we found that not all staff had completed appraisals.
- At the previous inspection the department had insufficient numbers of registered sick children's nurses (RSCNs) to meet the intercollegiate emergency standard. At this inspection the department had no RSCNs. This did not meet the national guidance.
- At the previous inspection we found that the department was not in line with the Royal College of Emergency Medicine (RCEM) guidance of providing 16 hour consultant. At this inspection we saw that this was met between Monday to Friday but not met over the weekend period.
- The mental health assessment room did not meet the Psychiatric Liaison Accreditation Network (PLAN).
- Patients were not always given pain relief medication.
- We were not assured the department had a stable leadership team.

However:

Urgent and emergency services

- Staff provided good care and treatment and gave patients enough to eat and drink. Managers monitored the effectiveness of the service and made sure staff were competent. Staff worked well together for the benefit of patients, advised them on how to lead healthier lives, supported them to make decisions about their care, and had access to good information.
- Key services were available seven days a week.
- We observed good multidisciplinary working.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. They provided emotional support to patients, families and carers.
- The service planned care to meet the needs of local people, took account of patients' individual needs, and made it easy for people to give feedback.

Is the service safe?

Inadequate ● ↓

Our rating of safe went down. We rated it as inadequate because:

- Whilst the service provided mandatory training in key skills including the highest level of life support training, staff in the department had not all completed the training. This included basic and advanced life support training for children and adults.
- The service provided safeguarding training to all staff but not all staff had completed the required training. We were not assured systems were in place to ensure everyone completed it.
- The service did not have enough substantive medical or nursing staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment, however bank, agency and locum staffing was used to fill most roster gaps. At the previous inspection the department had insufficient numbers of nursing and medical staff.
- At the previous inspection we found that the department was not in line with the Royal College of Emergency Medicine (RCEM) guidance of providing 16 hour consultant. At this inspection we saw this was met between Monday to Friday, but not met over the weekend period.
- The department had no registered sick children's nurses (RSCNs), this did not meet the intercollegiate emergency standard.
- During the inspection, we did not always observe staff washing their hands in-between patients.
- The design of the department did not meet the requirements to keep all patients safe. At this inspection the mental health assessment room did not meet the Psychiatric Liaison Accreditation Network (PLAN). There was poor observation of the children's waiting area.
- The time from arrival to initial assessment was worse than the overall England median in all months over the 12-month period from April 2018 to March 2019. From June 2018 and May 2019 there was an upward trend of ambulances handovers of more than 30 minutes however following our inspection information provided by the trust showed that from April 2019 to November 2019 there had been improvement in this metric. There had been 1,410 black breaches from June 2018 to May 2019.

However:

Urgent and emergency services

- The service controlled infection risk. They kept equipment and the premises visibly clean.
- Staff kept detailed records of patients care and treatment. Records were clear, up-to-date, stored securely and easily available to all staff providing care.
- The service used systems and processes to safely prescribe, administer, record and store medicines.
- Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service.

Is the service effective?

Requires improvement   

Our rating of effective stayed the same. We rated it as requires improvement because:

- The service did not consistently assure staff were competent for their roles. Managers did not always appraise staff's work performance.
- Whilst staff monitored the effectiveness of care and treatment, we were not assured the service used the findings to make improvements and achieved good outcomes for patients. At this inspection we found the service had completed internal audits to monitor progress against the RCEM audit standards. We found some improvement against some standards, but this was not consistent across all the required standards.
- Pain relief was not always given to patients.
- The service was not meeting the trust target for mental capacity act and deprivation of liberty training.
- Staff told us that because there was no additional training for the nurse streaming role, patients were being streamed to inappropriate practitioners, which caused delays to care.
- The departments unplanned re-attendance rate within seven days was worse than the national standard and worse than the England average.

However:

- Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. The service made adjustments for patients' religious, cultural and other needs.
- The service provided care and treatment based on national guidance and evidence-based practice.
- Staff assessed and monitored patients regularly to see if they were in pain.
- Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.
- Key services were available seven days a week to support timely patient care.
- Staff gave patients practical support and advice to lead healthier lives.

Is the service caring?

Good   

Urgent and emergency services

Our rating of caring stayed the same. We rated it as good because:

- Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.
- Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs.
- Staff supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment.

However:

- The department scored below the England average in the Friends and Family Test (FFT).

Is the service responsive?

Requires improvement  

Our rating of responsive went down. We rated it as requires improvement because:

- The trust consistently failed to meet the national four-hour standard for all patients to be seen and transferred or discharged.
- Staff told us that if patients had been waiting over two hours they would be reassessed. However, during our inspection we saw this was not happening.
- From June 2018 to May 2019, the trust's monthly median total time in urgent and emergency care for all patients was slightly worse than the England average.
- Staff did not always make reasonable adjustments to help patients access services.
- Complaints were not always investigated in a timely manner.
- People could not always access the service when they needed it and received the right care promptly. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were in line with national standards.

However:

- The service was inclusive and took account of patients' individual needs and preferences.
- The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff.

Is the service well-led?

Requires improvement   

Our rating of well-led stayed the same. We rated it as requires improvement because:

- There was unplanned changes in the leadership team, with short notice to staff. We were not assured the department had a stable leadership team in place.
- Leaders and staff did not always engage with patients, staff, equality groups, the public and local organisations to plan and manage services.

Urgent and emergency services

- There had been limited improvements made since our last inspection such as ensuring the department was in line with the Royal College of Emergency Medicine (RCEM) guidance of providing consultant or meeting the intercollegiate emergency standard for RCSNs.
- We saw limited evidence that leaders and teams used systems to manage performance effectively. Whilst some risks and issues were identified and escalated, there was limited evidence to show actions to reduce their impact were effective.
- There were limited examples of learning and improving services. Staff had a good understanding of quality improvement but there was limited evidence of any improvements made since our previous inspection.

However:

- Staff had regular opportunities to meet, discuss and learn from the performance of the service.
- Leaders operated effective governance processes, throughout the service and with partner organisations.

Areas for improvement

We found areas for improvement in this service. See the Areas for Improvement section above.

Medical care (including older people's care)

Requires improvement   

Key facts and figures

Scunthorpe General Hospital is part of Northern Lincolnshire and Goole NHS Foundation Trust providing medical care to people in Scunthorpe, Grimsby and the surrounding areas. Three sites across the trust provide medical care services: Diana, Princess of Wales (DPoW), Scunthorpe General Hospital (SGH) and Goole and District Hospital (GDH). Scunthorpe General Hospital provide medical care in a number of different specialties, which included general medicine, care of the elderly, respiratory medicine, diabetes/endocrinology, gastroenterology, neurology and stroke care. There were 195 beds located across eleven wards.

The medical wards / areas at Scunthorpe General Hospital were:

- Stroke Unit (SSRU) which included a hyper acute stroke unit.
- Planned investigations unit (PIU)
- Ward 2 – general medicine
- Ward 16 – general medicine
- Ward 17 – general medicine
- Ward 18 – haematology and oncology
- Ward 22 - respiratory medicine
- Ward 23 - gastroenterology
- Ward 24 - cardiology
- Coronary Care Unit (CCU) – cardiology
- Ambulatory care unit
- Clinical Decisions Unit (CDU) – acute general medicine

The hospital also had a cardiac catheter lab, an endoscopy unit and a discharge lounge on site that were included as part of the medical service inspection.

Following our inspection of the service in 2018, requirement notices were issued for medical services at Scunthorpe General Hospital.

We previously inspected the medical service at this hospital in May 2018 and rated the service as requires improvement overall, with good for caring and effective and requires improvement for safe, responsive and well-led.

Action the trust MUST take to improve:

- The trust must ensure learning from serious incidents is shared with staff and that learning is embedded to prevent similar incidents occurring in the future.
- The trust must ensure medical and nursing staff comply with mandatory training requirements and are appraised annually.
- The trust must ensure safe medical staffing levels are maintained and every effort is made to recruit to vacancies. This should include reviewing the current hospital at night arrangements and ensuring patients are reviewed daily.

Medical care (including older people's care)

- The trust must improve areas of care identified as needing improvement from national and local audits.
- The trust must improve the trust's referral to treatment time (RTT) for admitted pathways for medical patients.

Action the trust SHOULD take to improve:

- The trust should consider how themes and trends from lower harm incidents can be shared to improve practice.
- The trust should continue its work to improve patient flow throughout the hospital to reduce the number of ward moves, moves at night and outlying patients and ensure patients are cared for in the right place by the right speciality team.
- The trust should continue its plans to develop the respiratory ward area which will facilitate single sex accommodation and reduction in the number of mixed sex accommodation breaches.
- The trust should continue to promote a caring culture and engage staff to address any residual issues of bullying and intimidation and involve staff in ongoing service improvements.

We inspected the medical service from 24 to 27 September 2019, as part of an announced comprehensive inspection of the whole trust due to it being in special measures.

We visited all medical wards / areas and observed care and treatment being delivered. Before the inspection, we reviewed performance information from, and about, the trust. We looked at 18 complete patient records (and specific documentation in nine others, including prescribing of medication, consent, mental capacity and deprivation of liberty safeguards documents). We also interviewed members of nursing and medical staff and the senior management team who were responsible for leadership and oversight of the service. We spoke with 31 patients, seven relatives and 34 members of staff.

We observed patient care, the environment within wards, handovers and safety briefings. We also reviewed the hospital's performance data in respect of medicine services.

We also completed a further unannounced inspection on the 10 October 2019; we visited the medicine service areas on wards 22 (respiratory) and the hyper acute stroke unit (HASU). We interviewed key members of staff, medical staff and the senior management team who were responsible for leadership and oversight of the service. We spoke with seven members of staff.

Summary of this service

Our rating of this service stayed the same. We rated it as requires improvement because:

- Several areas for improvement had been identified at our previous inspection in 2018.

At this inspection we found a number of these had not been addressed. We found issues surrounding patient safety and the governance, oversight and quality monitoring of the medical care service.

- The service provided mandatory training in key skills to staff but had not ensured everyone had complete it. Overall mandatory training compliance did not meet the trust target of 85% for both nursing and medical staff. This was highlighted as a 'must do' action at the last inspection.
- Not all staff had completed training on how to recognise and report abuse. Nursing staff met three out of the five training modules and medical staff met none of the five modules against a trust target of 85%.

Medical care (including older people's care)

- Although managers regularly reviewed and adjusted staffing levels and skill mix we were not assured the service always had enough nursing staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. The service monitored nurse staffing levels for patients receiving acute non-invasive ventilation or for patients nursed on the hyper acute stroke unit (HASU) receiving level two care, therefore we were not assured that staffing levels were always safe. The service could not assure us that patients were nursed according to BTS guidelines and the National Institute for Health and Care Excellence guidance, which recommend one nurse to two patients.
- The service had a medical staffing vacancy rate of 26.6% at the time of inspection. There was still minimal medical cover out of hours, which was identified as a concern at the last inspection. We had concerns about the lack of support for junior doctors due to the acuity of patients and the workload of senior doctors.
- Patient records were mostly stored securely, version control was poor, and we found examples of documentation past it's review date in use. Confidential waste was stored in paper bags which were unsecured and accessible to patients and visitors. We observed confidential ward and patient hand over documents for three consecutive days listing patient names, dates of birth, medical history and treatment plans within the paper bag. We escalated this at the time of inspection and lacked assurance regarding senior management and oversight of this.
- Although the service used systems and processes to prescribe, administer and record medicines we were not assured that oxygen was prescribed or recorded in line with BTS guidance or in line with trust policy on all wards that we inspected. We lacked assurance regarding senior management and oversight of this.
- The service had a higher than expected risk of readmission for elective admissions in oncology and haematology and a higher than expected risk of readmission for non-elective admissions in respiratory medicine compared to the England average.
- The average length of patient stay for elective specialties in medical oncology and non-elective specialties in respiratory medicine was longer than the England average.
- There was a process surrounding staff appraisal; although not all staff had received an appraisal to assess their work performance and promote their professional development. Appraisal compliance did not meet the trust target of 95% for medical and nursing staff.
- Waiting times from referral to treatment were not in line with national standards. Five specialties were below the England average for admitted RTT (percentage within 18 weeks).
- The strategy for the medical division was still in draft format. Concerns remained about the pace of change and improvement implementation. We were not assured about management oversight in some areas.

However:

- Staff cared for patients with compassion and involved them in decisions about their care. Feedback from patients confirmed that staff treated them well and with kindness.
- The service achieved grade B overall in the Sentinel Stroke National Audit Programme (SSNAP).
- The endoscopy service was achieving two-week and urgent standards for investigation; it had achieved Joint Advisory Group (JAG) accreditation in June 2019 and had a 24-hours a day, seven days a week gastrointestinal bleed rota in place.

Medical care (including older people's care)

- Staff felt respected, supported and valued. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service. There had been changes to the senior management team and they had clear ideas and early plans for how the services needed to be developed. Staff spoke highly of the new head of nursing and the appointment of senior matrons. Staff morale had improved since the last inspection.

Is the service safe?

Requires improvement   

Our rating of safe stayed the same. We rated it as requires improvement because:

- The service provided mandatory training in key skills to staff but had not ensured that everyone had completed it. Overall mandatory training compliance did not meet the trust target for both nursing and medical staff. This was highlighted as a 'must do' action at the last inspection. The trust was currently reviewing the mandatory and specific role training competency model with a view to achieving 90% compliance at the end of March 2020.
- Not all staff had completed training on how to recognise and report abuse. Nursing staff met three out of the five safeguarding training modules and medical staff met none of the five modules against a trust target of 85%. The trust was currently reviewing the mandatory model with a view to achieving 90% compliance at the end of March 2020.
- Although managers regularly reviewed and adjusted staffing levels and skill mix we were not assured the service always had enough nursing staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. The service monitored nurse staffing levels for patients receiving acute non-invasive ventilation or for patients nursed on the hyper acute stroke unit (HASU) receiving level two care, therefore we were not assured that staffing levels were always safe. The service could not assure us that patients were nursed according to BTS guidelines and the National Institute for Health and Care Excellence guidance, which recommend one nurse to two patients.
- The service had a medical staffing vacancy rate of 26.6% at the time of inspection. There was still minimal medical cover out of hours, which was identified as a concern at the last inspection. We had concerns about the lack of support for junior doctors due to the acuity of patients and the workload of senior doctors.
- Although the service used systems and processes to administer and record medicines we were not assured that oxygen was prescribed or recorded in line with British Thoracic Society (BTS) guidance on all wards that we inspected.
- Patient records were mostly stored securely, version control was poor, and we found examples of documentation past it's review date in use.
- During inspection of all medicine wards we saw confidential waste was stored in paper bags which were unsecured and accessible to patients and visitors. We observed confidential ward and patient hand over documents for three consecutive days listing patient names, dates of birth, medical history and treatment plans within the bag. We escalated this at the time of inspection and lacked assurance that senior management had oversight of this.

However:

- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so.
- The service had suitable premises and equipment and looked after them well. We found the hospital was accessible to wheelchair users, with clear signage.

Medical care (including older people's care)

- The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.
- Staff completed and updated risk assessments for each patient and removed or minimised risks.

Is the service effective?

Good   

Our rating of effective stayed the same. We rated it as good because:

- Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. The service made adjustments for patients' religious, cultural and other preferences.
- Staff assessed and monitored patients regularly to see if they were in pain. Pain relief was provided as prescribed and there were systems to make sure additional pain relief was available if required.
- Staff monitored the effectiveness of care and treatment through clinical audit. They used the findings to make improvements and achieved good outcomes for patients. The service had been accredited under relevant clinical accreditation schemes. For example, they had achieved Joint Advisory Group accreditation for their endoscopy services.
- The service achieved grade B overall in the Sentinel Stroke National Audit Programme (SSNAP).
- Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health. They used agreed personalised measures that limited patients' liberty.
- Staff of different grades and disciplines worked together as a team to benefit patients. Doctors, nurses and other healthcare professionals supported each other to provide good care.
- Key services were available seven days a week to support timely patient care.
- Staff gave patients practical support and advice to lead healthier lives.

However:

- Although the service monitored the effectiveness of care and treatment the service had a higher than expected risk of readmission for elective admissions and a higher than expected risk for non-elective admissions. From February 2018 to January 2019, patients at Scunthorpe General Hospital had a higher than expected risk of readmission for elective admissions in medical oncology and haematology and a higher than expected risk of readmission for non-elective admissions in respiratory medicine when compared to the England average.
- There was a process surrounding staff appraisal; although not all staff had received an appraisal to assess their work performance and promote their professional development. Appraisal compliance did not meet the trust target of 95% for medical and nursing staff. The trust was reviewing the appraisal model with a view to reducing the compliance target to 85% and instigating an appraisal cycle, with the intention of achieving 85% compliance at the end of March 2020.

Medical care (including older people's care)

- Although staff knew how to support patients who lacked capacity to make their own decisions Mental Capacity Act and Deprivation of Liberty Safeguards training compliance did not meet the trust target of 85% for both medical and nursing staff. Nursing staff met one out of two training modules, whilst medical staff failed to meet both modules. The trust was currently reviewing the mandatory and specific role training competency model with a view to achieving 90% compliance at the end of March 2020.

Is the service caring?

Good   

Our rating of caring stayed the same. We rated it as good because:

- Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs. Feedback from the patients and relatives we spoke with was positive. We observed members of staff providing care for patients in a kind and compassionate way. Staff communicated with patients in a caring manner regardless of whether they were conscious or unconscious.
- People were treated with dignity by all those involved in their care, treatment and support. Consideration of people's privacy and dignity was embedded, and staff were aware of patients' specific needs; these were recorded and communicated.
- Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs. People who used the service and those close to them were actively involved in their care. Staff were fully committed to working in partnership with people. They supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment.
- Staff empowered people who used the service to have a voice. They showed determination and creativity to overcome obstacles to delivering care. People's individual preferences and needs were reflected in how care was delivered.
- Staff recognised and respected the totality of people's needs. They took people's personal, cultural, social and religious needs into account, and found innovative ways to meet them. People's emotional and social needs were seen as being as important as their physical needs.
- The Patient Led Audit of the Care Environment (PLACE) score for privacy, dignity and wellbeing was 88.52%, which was higher than the national average of 84.16%.

Is the service responsive?

Requires improvement   

Our rating of responsive stayed the same. We rated it as requires improvement because:

- Waiting times from referral to treatment were not in line with national standards. Five specialties were below the England average for admitted RTT (percentage within 18 weeks). From June 2018 to May 2019 the trust's referral to treatment time (RTT) for admitted pathways for medical services was worse than the England average. This was highlighted as a 'must do' action at the last inspection; we lacked assurance how the service would improve upon this.

Medical care (including older people's care)

- The average length of patient stay for elective specialties in medical oncology and non-elective specialties in respiratory medicine was longer than the England average. This was adversely affected by funding issues for some patients out of area and by the inability of nursing or care homes to re-establish care packages when patient acuity changed.
- From April 2018 to March 2019 there were 775 reported delayed discharges at SGH. Although, this was an improving picture with numbers falling from 99 in month one to 56 in month 12.
- Although the service treated concerns and complaints seriously the medicine service took an average of 76.9 working days to investigate and close complaints. From June 2018 to June 2019, the trust received 52 complaints in relation to medicine at Scunthorpe General Hospital; 41.3% of these were still open and under investigation. Of the closed complaints, the trust took an average of 76.9 working days to investigate and close. This was not in line with their complaints policy, which states complaints should be completed within 60 working days.

However:

- Key services were available seven days a week to support timely patient care. The endoscopy service was achieving two-week and urgent standards for investigation and had achieved Joint Advisory Group (JAG) accreditation in June 2019. There was a 24-hours a day, seven days a week gastrointestinal bleed rota in place.
- The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers. We saw some good examples of where staff had made special arrangements to meet an individual patient's needs.
- The frail elderly assessment team (FEAST) had been successful in avoiding unnecessary admissions and the ambulatory care unit was developing its services and had implemented outreach support to patients in their own homes.
- Trust data showed that from January 2017 to December 2017 there were 371 patients moved at night at SGH. At this inspection, from June 2018 to May 2019, 136 patients had moved wards at night.
- At this inspection we saw an improving picture in terms of mixed sex accommodation with no breaches reported between March 2019 to August 2019.

Is the service well-led?

Requires improvement   

Our rating of well-led stayed the same. We rated it as requires improvement because:

- Although leaders understood the priorities and issues the service faced there had been limited improvements made since our last inspection; we were concerned about lack of management oversight and pace of change.
- At our last inspection we said the trust must ensure medical and nursing staff comply with mandatory training requirements. At this inspection we found mandatory training compliance targets, including those for safeguarding training, were still not being met.
- The service did not monitor nurse staffing levels for patients receiving acute non-invasive ventilation and acute care following stroke thrombolysis treatment. The service could not assure us that patients were nursed according to British Thoracic Society guidelines and National Institute for Health and Care Excellence guidance which recommended one nurse to two patients. We lacked assurance that senior management had oversight of this.

Medical care (including older people's care)

- At our last inspection we said the trust must ensure safe medical staffing levels were maintained and hospital at night arrangements should be reviewed. At this inspection we continued to see a high number of medical vacancies and were told that overnight medical cover and support for junior doctors was still a concern.
- At our last inspection we said the trust must ensure safe medicines management; at this inspection we had concerns around lack of oxygen prescribing and management of this.
- We saw limited evidence that leaders and teams used systems to manage performance effectively. At our last inspection we said the trust must improve its referral to treatment time for medical patients. The trust's RTT performance had deteriorated since the last inspection and we were not assured the senior leadership team were moving at pace to improve this.
- Although the service had a vision for what it wanted to achieve and a strategy to turn it into action the strategy and vision were still in draft form and were not embedded. Most staff that we spoke with were unaware of the medicine strategy and vision. This was highlighted as an issue at our last inspection.
- The service did not always store or dispose of confidential paper records securely and some version-controlled documentation was out of date. We found this issue in several areas so were not assured there was management oversight.
- There were limited examples of learning and improving services. Staff had a good understanding of quality improvement and there was some evidence of improvements made since our previous inspection.

However:

- Staff spoke positively about their leaders and felt respected.
- The service collected, analysed, and used information well to support all its activities, using secure electronic systems with security safeguards.
- The service engaged well with patients, staff, the public and local organisations to plan and manage services and collaborated with partner organisations effectively.
- Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity and provided opportunities for career development. There was an open culture where patients, their families and staff could raise concerns without fear.

Areas for improvement

We found areas for improvement in this service. See the Areas for Improvement section above.

Surgery

Requires improvement   

Key facts and figures

Surgical services at Northern Lincolnshire and Goole NHS Foundation trust provides elective and emergency surgical care to patients.

The hospital has four surgical wards and six operating theatres. The surgery division provides acute, elective and day case surgery covering 10 surgical specialities including; breast, colorectal, ear, nose and throat (ENT), general surgery, ophthalmology, orthodontics, oral-maxillofacial upper gastrointestinal, orthopaedics, trauma and urology. Pain services and pre-assessment facilities are also available on this site.

The hospital has 76 inpatient surgical beds, including four high observation beds.

The trust had 44,865 surgical admissions from March 2018 to February 2019. Emergency admissions accounted for 10,095 (22.5%), 31,243 (69.6%) were day case, and the remaining 3,527 (7.9%) were elective.

We inspected surgical services as part of an announced comprehensive inspection of the whole trust due to the trust being in special measures.

Surgical services were last inspected in Scunthorpe in May 2018, where all five domains in surgery were inspected and an overall rating of requires improvement was given, Well led was rated as inadequate, safe, effective, responsive were all rated as requires improvement and caring was rated as good.

The main areas of concern from the last inspection and the areas in surgery where the trust was told to improve were:

- The trust must ensure that effective processes are in place to enable improvement on the number of fractured neck of femur patients who have surgery within 48 hours.
- The trust must ensure that performance in all national audits improves and that action plans address the correct issues to ensure performance improves.
- The trust must improve on national treatment performance standards.
- The trust must ensure that there are sufficient qualified, competent, skilled and experienced persons to meet the needs of patients using the services.
- The trust must ensure that patients are fasted pre-operatively in line with best practice recommendations.
- The trust must ensure that 95% of staff have an up to date appraisal in line with their own target.
- The trust must ensure that mandatory training compliance for all staff meets their own target.
- The trust must ensure that effective processes are in place to reduce the number of cancelled operations.
- The trust must ensure that policies and guidelines in use within clinical areas are compliant with NICE or other clinical bodies.
- The trust must ensure that service risks are identified, reviewed, updated and senior management teams have oversight.
- Define and complete the vision and strategy for the surgical services in a timely manner.
- Ensure timely repair and maintenance of estates and facilities issues within the operating theatre department.

Surgery

- The trust must ensure that a patient's capacity is clearly documented and where a patient is deemed to lack capacity this is assessed and managed appropriately in line with the Mental Capacity Act (2015).

We also said that the trust should:

- The trust should continue to ensure the proper and safe management of medicines including: checking that fridge temperatures used for the storage of medicines are checked on a daily basis in line with the trust's policy.
- The trust should continue to ensure that actions are taken to enable staff to raise concerns without fear of negative repercussions.
- The trust should continue to ensure that resuscitation equipment is regularly checked and tested consistently and in line with trust policy.
- The trust should continue to ensure that patients are assessed for delirium in line with national guidance.
- The trust should ensure that staff complete Mental Capacity Act training.
- The trust should take steps to improve its staff and public engagement activities.

During the inspection, we visited the surgical wards, operating theatres and recovery areas and day surgery unit. We spoke with 14 patients and 35 members of staff. We observed staff delivering care and reviewed 31 sets of patient records and prescription charts. We also reviewed trust policies and performance information, from and about the trust.

Summary of this service

Our rating of safe stayed the same. We rated it as requires improvement because:

- The division had limited evidence to show that all areas requiring improvement from the last inspection had been acted upon, embedded or sustained.
- The service had a vision for what it wanted to achieve and had developed a draft strategy to turn it into action, however we saw limited evidence that this had been developed with all relevant stakeholders.
- Leaders had governance processes, however we did not see issues escalated and discussed in an effective way.
- Leaders and teams had systems to manage performance. However, these were not consistently used to improve performance. We saw limited evidence of identifying and escalating relevant risks and issues and identified actions to reduce their impact.
- Records used within the division were not completed consistently or controlled in a safe manner.
- Documentation of consent was not always completed in line with national guidance. Consent forms we reviewed did not provide assurance with best practice requirements and the hospital policy in relation to the recording of consent.
- Complaints investigations were not carried out in a timely way. The division took an average of 120.9 working days to investigate and close complaints, this was worse than the trust policy of investigation and closure within 60 working days.
- The division did not always respond to incidents appropriately or in a timely way, and there was not always appropriate oversight of incident themes and trends. The service had declared serious incidents relating to missed appointments and referrals because of a backlog people waiting for outpatients' appointments; we were not assured this risk was mitigated and would not reoccur.

Surgery

- The service did not consistently provide care and treatment based on national guidance and evidence-based practice. There was not an effective process to enable access to theatres and ensure cases were clinically prioritised appropriately.
- We had previously highlighted that pre-assessment service required improvement in relation to clinical pathways, clinical cancellations of patients and competence of staff. At this inspection we only saw limited improvement.
- People were not consistently able to access the service when they needed it and receive the right care promptly. A number of patients were waiting longer than 52 weeks for treatment or had their operations cancelled. When cancelled the service did not consistently ensure that patients were treated within 28 days.
- Staff did not consistently record fluid provided to patients. Fluid charts we reviewed were not consistently record the daily intake and output on all fluid charts we reviewed.
- Staff monitored the effectiveness of care and treatment but did not consistently use the findings in a timely way to make improvements and achieve good outcomes for patients.
- The design, maintenance and use of facilities, premises and equipment did not consistently keep people safe. We did not receive assurance that all theatres had received verification testing in the previous 12 months.
- The service did not consistently plan or provide care in a way that met the needs of local people and the communities served.
- The service continued to breach mixed sex accommodation policies in the high observation bays.
- The service did not have effective systems and processes to ensure mandatory training was completed by all staff, including safeguarding and mental capacity act training was completed by all staff. Compliance rates for medical staff compliance significantly below the target.
- Appraisal rates for staff did not meet the trust target of 95%, however this was improving, and staff we spoke with said they felt support by managers.
- The service had a vision for what it wanted to achieve and had developed a draft strategy to turn it into action, we saw limited evidence that this had been developed with all relevant stakeholders.

However:

- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. The trust provided training on how to recognise and report abuse, and they knew how to apply it.
- On the majority of occasions, the service had enough nursing and support staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment.
- We saw improvements in the fractured neck of femur pathways, with the majority of patients now having surgery on the day of or the day after admission. This progress needs to be sustained.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

Is the service safe?

Requires improvement   

Our rating of safe stayed the same. We rated it as requires improvement because:

Surgery

- The division did not always respond to incidents appropriately or in a timely way, and there was not always appropriate oversight of incident themes and trends. The service had declared serious incidents relating to missed appointments and referrals because of a backlog people waiting for outpatients' appointments; we were not assured this risk was mitigated and would not reoccur.
- Records used within the division were not completed consistently or controlled in a safe manner. Staff kept detailed records of patients' care and treatment, however these were not consistently recorded on the correct, version-controlled form.
- We had previously highlighted the pre-assessment service required improvement in relation to clinical pathways, clinical cancellations of patients and competence of staff. At this inspection, we saw some improvements in surgical pathways, however, we were still aware that patients were not being assessed for surgery in a consistent and effective way by fully trained, competent pre-assessment staff. Changes needed more pace and a further period of embedding to provide assurance that the service was effective and responsive to clinical needs.
- The service did not have effective systems and processes to ensure mandatory training including safeguarding was completed by all staff. Compliance rates were particularly poor for medical staff.
- The design, maintenance and use of facilities, premises and equipment did not consistently keep people safe. We did not receive assurance that all theatres had received verification testing in the previous 12 months.
- Staff did not consistently complete and update risk assessments for each patient to remove or minimise risks.

However:

- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. The trust provided training on how to recognise and report abuse, and they knew how to apply it.
- On the majority of occasions, the service had enough nursing and support staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment.

Is the service effective?

Requires improvement ● ➡ ➡

Our rating of effective stayed the same. We rated it as requires improvement because:

- Documentation of consent was not always completed in line with national guidance. Consent forms we reviewed did not provide assurance with best practice requirements and the hospital policy in relation to the recording of consent. Consent was not consistently recorded as being confirmed on the day of surgery and patients were not always provided with a copy of the consent form following completion.
- The service did not consistently provide care and treatment based on national guidance and evidence-based practice. At the previous inspection, we highlighted that there was not an effective process to enable access to theatres and ensure cases were clinically prioritised appropriately. From our observations at this inspection, it was apparent that some improvements had occurred, however these were not consistently applied for all patients requiring access to emergency theatres.
- Staff monitored the effectiveness of care and treatment but did not consistently use the findings in a timely way to make improvements.
- Mental Capacity Act training compliance did not meet the trust target, with medical staff compliance significantly below the target.

Surgery

- Staff did not consistently record fluid provided to patients. Fluid charts we reviewed were not consistently record the daily intake and output on all fluid charts we reviewed.
- Appraisal rates for staff did not meet the trust target of 95%, however this was improving, and staff we spoke with said they felt support by managers.

However:

- We saw improvements in the fractured neck of femur pathways, with the majority of patients now having surgery on the day of or the day after admission.
- All patients at Scunthorpe General Hospital had a lower than expected risk of readmission for non-elective admissions when compared to the England average.
- Staff assessed and monitored patients regularly to see if they were in pain and gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.
- Staff we spoke with and care we observed showed that all staff disciplines were supportive, and they had positive working relationships.

Is the service caring?

Good ● ➡ ➡

Our rating of caring stayed the same. We rated it as good because:

- Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs. On the majority of patients, we spoke with described their care in positive terms.
- Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs.
- Staff supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment.
- We observed privacy and dignity being maintained for patients receiving care.

However:

- From June 2018 to May 2019, the Friends and Family Test response rate for surgery at Northern Lincolnshire and Goole NHS Foundation Trust was 13%, which was worse than the England average of 27%.

Is the service responsive?

Requires improvement ● ➡ ➡

Our rating of responsive stayed the same. We rated it as requires improvement because:

- People were not consistently able to access the service when they needed it and receive the right care promptly. A number of patients were waiting longer than 52 weeks for treatment or had their operations cancelled. When cancelled the service did not consistently ensure that patients were treated within 28 days.

Surgery

- Complaint investigations were not carried out in a timely way. The division did not respond and close patient complaints within 60 working days. From June 2018 to June 2019, the trust received 87 complaints in relation to surgery at the trust (17.9% of total complaints received by the trust). The trust took an average of 120.9 working days to investigate and close complaints.
- The service did not consistently plan or provide care in a way that met the needs of local people and the communities served.
- The service continued to breach mixed sex accommodation in the high observation bays.

However:

- The trust referral to treatment time (RTT) for admitted pathways for surgery was about the same as the England average. In the latest period, May 2019, performance was slightly higher (67.1%), when compared to the England average (64.7%).
- From March 2018 to February 2019, the average length of stay for patients having elective surgery at the trust was better than the England average.
- The service took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.

Is the service well-led?

Requires improvement  

Our rating of well-led improved. We rated it as requires improvement because:

- The division had limited evidence to show that all areas requiring improvement from the last inspection had been acted upon, embedded or sustained.
- The service had a vision for what it wanted to achieve and had developed a draft strategy to turn it into action, however we saw limited evidence that this had been developed with all relevant stakeholders.
- Leaders had governance processes, however we did not see issues escalated and discussed in an effective way. The governance structure internally within the division and externally within the trust needed strengthening to show evidence of risk and performance discussion.
- Leaders and teams had systems to manage performance. However, these were not consistently used to improve performance. We saw limited evidence of identifying and escalating relevant risks and issues and identified actions to reduce their impact.

However:

- At this inspection we saw more stability within leadership roles. Since the last inspection the senior management team had undergone further changes. These changes had an impact on the decision making, pace of change, governance and oversight of the issues within surgery.
- Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service, however some of the discussion were limited.
- Staff moral had improved, staff we spoke with said that they felt supported by the senior leaders.

Surgery

Areas for improvement

We found areas for improvement in this service. See the Areas for Improvement section above.

Critical care

Good  

Key facts and figures

Northern Lincolnshire and Goole NHS Foundation Trust has two critical care units. Scunthorpe General Hospital (SGH) has an eight-bedded level two and three intensive care (ICU) facility. This provided level two (patients who require preoperative optimisation, extended post-operative care or single organ support) and level three (patients who require advanced respiratory support or a minimum of two organ support) care. The unit has a bay containing six beds and two single rooms. The beds flexed between level two and level three as required. The unit could care for a maximum of six level three patients.

A critical care outreach team provided a supportive role to the wards medical and nursing staff when caring for deteriorating patients and support to patients discharged from critical care. The team was available seven days a week.

The critical care service is part of the East Yorkshire and Humberside Critical Care Network. The units did not accept paediatric admissions. However, they held paediatric resuscitation equipment in the event of an emergency or if a young person required stabilisation prior to a transfer.

The anaesthetist or consultants would attend in an emergency and stabilise the patient until a bed was available on the neonatal ICU or until the dedicated intensive care transport service for children arrived. The unit had an inter hospital transfer policy which was in line with the critical care network and national guidelines.

Our inspection was part of an announced comprehensive inspection of the whole trust, this was due to it being in special measures.

We re-inspected all five key questions during this inspection. During this inspection we visited the intensive care unit and the high dependency unit. We spoke with three relatives and 10 members of staff. It was not appropriate to speak to any of the patients at the time of the inspection.

We observed staff delivering care, looked at four patient records and four prescription charts. We reviewed trust policies and performance information from, and about, the trust. We received comments from patients and members of the public who contacted us directly to tell us about their experiences.

Summary of this service

Our rating of this service improved. We rated it as good because:

- We found that the Guidelines for the Provision of Intensive Care Services (GPICS) standard which states 50% of all nursing staff should hold a post graduate qualification in critical care nursing was met. Data showed that 55% of staff had the appropriate qualification.
- The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.
- The service used systems and processes to safely prescribe, administer, record and store medicines. During our inspection we found stock medicines within the unit were handled safely and stored securely. Controlled drugs were appropriately stored with access restricted to authorised staff.

Critical care

- Managers appraised staff's work performance and held supervision meetings with them to provide support and development. Data submitted at the time of inspection showed that nursing staff working on HDU and ICU at Scunthorpe General Hospital had achieved an appraisal rate of 100% against a trust target of 85%.
- Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care. Multidisciplinary team working was in line with GPICS recommendations. Physiotherapy staff confirmed that in line with GPICS recommendations they were able to provide the respiratory management and rehabilitation components of care.
- Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health. The information provided by the trust showed 94.3% of nursing and 88% of medical staff were compliant with MCA training. This met the trust target of 85%. We found the processes for sepsis and delirium screening was undertaken on the unit.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.
- The service was inclusive and took account of patients' individual needs and preferences. We saw that there were measures taken to reduce noise in the main unit. There had been implementation of sleep bundles (soft close bins, eye masks, ear plugs, clocks which show night and day etc). There was an electronic ear which changed colour when the volume was too high.
- People could access the service when they needed it and received the right care promptly. The decision to admit to the unit was made following a discussion between the critical care consultant and the consultant or doctors already caring for the patient. From the notes we reviewed all the patients had been reviewed by a consultant within 12 hours of admission. This met the GPICS standard.
- We were provided with the most recent ICNARC quarterly quality report. This showed that between April 2018 and 31 March 2019 the percentage of care post eight-hour delay rate was 1.5% this was significantly better than similar units which had an average of 5.5%.
- It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. From June 2018 to June 2019 the trust received only one complaint.
- Leaders had the skills and abilities to run the service. They were visible and approachable in the service for patients and staff. Leadership of the service was in line with GPICS standards. From discussions with the leadership team it was clear they understood the current challenges and pressures impacting on service delivery and patient care. The frontline leadership differed on each site.
- There was a strong and embedded ward management team. Staff we spoke with reported feeling very supported by their team and managers and stated they were able to escalate any concerns.
- HDU and ICU continued to function as one unit with full inter-unit working.
- Staff felt respected, supported and valued. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

However:

Critical care

- The service did not have enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. We found the same situation with regards to medical staffing as at the previous inspection, in that it was not in line with GPICS standards. Not all care was delivered by intensivists, and on call consultants had other areas of responsibility.
- The medical staffing rota did not provide continuity of care for patients as a different consultant attended each day. This was not in line with GPICS standards.
- The percentage of staff assessed as competent to use the ventilators across the critical care division was 91% as of September 2019. All staff had received theory training on the use of ventilators with three remaining staff members to complete the competency statement.
- We were advised that staff were moved from the ward to work on other areas on a frequent basis. We observed that when this occurred it resulted in the co-ordinator no longer being in a position to provide supernumerary support. This does not meet with GPICS standards.
- Intensive Care National Audit and Research Centre (ICNARC) data showed there had been six unit acquired infections in the ITU / HDU between 1 April 2018 and 31 March 2019. This was worse compared to similar units (2.6 against 1.1 unit acquired infections in blood per 1000 patient bed days). Just over 81.4 percent of nursing staff had completed infection control training. This did not meet the trust target of 85%.
- The service did not always provide care and treatment based on national guidance and evidence-based practice. Information from the July 2019 governance meeting minutes showed that the division were not meeting compliance against all the National Institute for Health and Care Excellence (NICE) guidance, with a few outstanding. However, the minutes were not specific to which NICE guidance this linked to.
- The service provided mandatory training in key skills to staff but had not ensured everyone had complete it. The 85% target was not met for three of the nine mandatory training modules for which qualified nursing staff were eligible.
- Not all staff had training on how to recognise and report abuse. In addition, the 85% target was not met for one of the three safeguarding training modules for which qualified nursing staff were eligible.
- Not all services were available seven days a week to support timely patient care. We saw from patient records daily consultant led ward rounds took place, however these were not always led by a consultant intensivist due to the lack of these consultants within the trust. This was not in line with GPICS recommendations.

Is the service safe?

Requires improvement ● ➡ ➡

Our rating of safe stayed the same. We rated it as requires improvement because:

- The service did not have enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. We found the same situation with regards to medical staffing as at the previous inspection, in that it was not in line with GPICS standards. Not all care was delivered by intensivists, and on call consultants had other areas of responsibility.
- In addition, the rota did not provide continuity of care for patients as a different consultant attended each day. This was not in line with GPICS standards.
- The percentage of staff assessed as competent to use the ventilators across the critical care division was 91% as of September 2019. All staff had received theory training on the use of ventilators with three remaining staff members to complete the competency statement.

Critical care

- We were advised that staff were moved from the ward to work on other areas on a frequent basis. We observed that when this occurred it resulted in the co-ordinator no longer being in a position to provide supernumerary support. This does not meet with GPICS standards.
- Intensive Care National Audit and Research Centre (ICNARC) data showed there had been seven unit acquired infections in the ITU / HDU between 1 April 2018 and 31 March 2019. This was worse compared to similar units (2.6 against 1.1 unit acquired infections in blood per 1000 patient bed days). Just over 81.4 percent of nursing staff had completed infection control training. This did not meet the trust target of 85%.
- The service provided mandatory training in key skills to staff but had not ensured everyone had complete it. The 85% target was not met for three of the nine mandatory training modules for which qualified nursing staff were eligible.
- Not all staff had training on how to recognise and report abuse. In addition, the 85% target was not met for one of the three safeguarding training modules for which qualified nursing staff were eligible.

However:

- We found that the GPICS standard which states 50% of all nursing staff should hold a post graduate qualification in critical care nursing was met. Data showed that 55% of staff had the appropriate qualification.
- The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.
- The service used systems and processes to safely prescribe, administer, record and store medicines. During our inspection we found stock medicines within the unit were handled safely and stored securely. Controlled drugs were appropriately stored with access restricted to authorised staff.

Is the service effective?

Good ● ↑

Our rating of effective improved. We rated it as good because:

- Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. The service made adjustments for patients' religious, cultural and other needs. Protocols for critical care nutritional pathways were in place and embedded.
- Staff assessed and monitored patients regularly to see if they were in pain and gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain. We found assessment and monitoring of pain and we observed care plans to support this.
- Managers appraised staff's work performance and held supervision meetings with them to provide support and development. Data submitted at the time of inspection showed that nursing staff working on HDU and ICU at Scunthorpe General Hospital had achieved an appraisal rate of 100% against a trust target of 85%.
- Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care. Multidisciplinary team working was in line with GPICS recommendations. Physiotherapy staff confirmed that in line with GPICS recommendations they were able to provide the respiratory management and rehabilitation components of care.

Critical care

- Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health. The information provided by the trust showed 94.3% of nursing and 88% of medical staff were compliant with MCA training. This met the trust target of 85%. We found the processes for sepsis and delirium screening was undertaken on the unit.

However:

- The service did not always keep up to date with care and treatment based on national guidance and evidence-based practice. Information from the July 2019 governance meeting minutes showed that the division were not up to date with all the National Institute for Health and Care Excellence (NICE) guidance, with a few outstanding. However, the minutes were not specific to which NICE guidance this linked to.
- Not all services were available seven days a week to support timely patient care. We saw from patient records daily consultant led ward rounds took place, however these were not always led by a consultant intensivist due to the lack of these consultants within the trust. This was not in line with GPICS recommendations.

Is the service caring?

Good   

Our rating of caring stayed the same. We rated it as good because:

- Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs. Feedback from the patients and relatives we spoke with was positive. We observed members of staff providing care for patients' in a kind and compassionate way. Staff communicated with patients in a caring manner regardless of whether they were conscious or unconscious.
- Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs. The critical care outreach team provided psychological support as part of their role. Specialist nurses were also available to provide advice and support.
- Staff supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment. The patient records we reviewed showed evidence of patient and carer involvement. This was supported by patients and the families we spoke with.
- There was an opportunity for patients and relatives to join the patient relative forum to discuss their experiences and receive support. This was improved following a recommendation from the previous inspection report.

Is the service responsive?

Good   

Our rating of responsive stayed the same. We rated it as good because:

- The service planned and provided care in a way that met the needs of local people and the communities served.
- The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services. We saw that there were measures taken to reduce noise in the main unit. There had been implementation of sleep bundles (soft close bins, eye masks, ear plugs, clocks which show night and day etc). There was an electronic ear which changed colour when the volume was too high.

Critical care

- We saw evidence in patient records that care plans included assessment and interventions for any patients with additional needs. This information would be communicated to all staff during handovers.
- Staff recognised the importance of speaking with relatives and carers for any patients with additional needs. Staff would seek support from the nurse in charge if they had any concerns, or they could access specialist nurses. The patient records that we reviewed reflected that individual needs were assessed, and care planning was informed by this.
- Staff were encouraged to complete patient diaries for level three patients and any other patients who stayed on the unit for more than 72 hours. We found the use of these was embedded amongst staff. The service had a critical care patient and relative support group.
- People could access the service when they needed it and received the right care promptly. The decision to admit to the unit was made following a discussion between the critical care consultant and the consultant or doctors already caring for the patient. From the notes we reviewed all the patients had been reviewed by a consultant within 12 hours of admission. This met the GPICS standard.
- We were provided with the most recent ICNARC quarterly quality report. This showed that between April 2018 and 31 March 2019 the percentage of care post eight-hour delay rate was 1.5% this was significantly better than similar units which had an average of 5.5%.
- It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. From June 2018 to June 2019 the trust received only one complaint.

However:

- There was nowhere for food to be obtained during the night. There were no facilities for relatives to stay overnight.

Is the service well-led?

Good   

Our rating of well-led stayed the same. We rated it as good because:

- Leaders had the skills and abilities to run the service. They were visible and approachable in the service for patients and staff. Leadership of the service was in line with GPICS standards. From discussions with the leadership team it was clear they understood the current challenges and pressures impacting on service delivery and patient care. The frontline leadership differed on each site.
- There was a strong and embedded ward management team. Staff we spoke with reported feeling very supported by their team and managers and stated they were able to escalate any concerns.
- HDU and ICU continued to function as one unit with full inter-unit working.
- Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service had an open culture where patients, their families and staff could raise concerns without fear.
- Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.
- All staff we spoke with told us of the importance of being open and honest to patients and relatives if there had been a mistake in their care.

Critical care

- Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements.
- Leaders and staff actively and openly engaged with patients, and staff. Work had been done to improve engagement with families and patients. We saw that the use of patient diaries was embedded. We saw completion of ward surveys and the implementation of a support forum for patients and relatives.
- We saw that the divisional risk register was up to date and regularly reviewed.
- The unit was looking to change the way shift patterns and rota allocations took place. There had been discussions held regarding a flexible shift pattern where staff could be stood down if not required, remain at home on call and work during busier periods.

However:

- We identified that morale on the ICU was mixed. Some concerns were identified in relation to staff movement from critical care to other areas. At the last inspection we were assured managers were aware of this and were taking steps to resolve these issues. However, there appeared to be no improvement.
- We were not aware of any involvement or participation in research.

Areas for improvement

We found areas for improvement in this service. See the Areas for Improvement section above.

Maternity

Requires improvement  

Key facts and figures

Northern Lincolnshire and Goole NHS Foundation Trust provides a range of maternity services for women at three acute hospital sites. The trust has 72 acute maternity beds located across six wards; four wards at Diana, Princess of Wales hospital, and two at Scunthorpe General hospital. At Goole and District Hospital, the hospital offers daily antenatal midwife led clinics with a weekly obstetric clinic, there is also a one-bedded midwifery-led birthing suite available on site.

At Scunthorpe General Hospital, maternity services are based on a traditional model. The seven bedded central delivery suite incorporates a dedicated obstetric theatre and has a birthing pool. There is a 27-bedded mixed antenatal and postnatal ward, where midwives provide care for women having inductions of labour, observations for complications and women resting following the birth of their baby. The ward also offers transitional care.

Antenatal obstetric high-risk clinics are provided Monday to Friday. The antenatal day unit is available every day. Obstetric ultrasonography facilities are available to fully support screening programmes and fetal/maternal well-being surveillance.

Across the trust, community midwives are based within Children's Centres across North East Lincolnshire and some of East Lincolnshire (i.e. Louth and the surrounding area). Four community midwifery teams (Scunthorpe central ('town'), Brigg and Barton, Isle and Crowle and Goole teams) provide maternity services at the hospital and to women and babies in the surrounding communities.

From April 2018 to March 2019, there were 1650 deliveries at Scunthorpe General Hospital, and 34 home births across Scunthorpe and Goole community services.

During our inspection, we visited the maternity unit and spoke with eight patients and their companions, and 36 members of staff. These included matrons, ward managers, doctors, midwives, and health care assistants. We observed care and treatment, looked at eight complete patient records, and five medicines charts. We also interviewed key members of staff, medical staff and the senior management team who were responsible for the leadership and oversight of the service.

Summary of this service

Our rating of this service went down. We rated it as requires improvement because:

- The design, maintenance and use of facilities, premises and equipment did not always keep people safe; there was a risk of delayed access to the central delivery suite and theatres. Out of hours (duty) anaesthetist cover was shared with the intensive care unit; and we were not assured the anaesthetist could be immediately available to cover emergency work on delivery suite, without potentially placing patients at risk.
- Not all staff were up to date with key mandatory training; including obstetric emergency, resuscitation, adults safeguarding and Mental Capacity training. The service had not provided quarterly 'live' (unannounced) emergency skills and drills training, in line with trust policy. The appraisal rate for medical staff was low and did not meet trust target.

Maternity

- Leaders and senior staff had the necessary experience and knowledge to lead effectively. However, there was an unstable leadership team structure. Staff expressed concerns about leadership stability and the implementation of new models of care; and described morale within the service had wavered. The service did not have an agreed vision for what it wanted to achieve and the strategy to turn it into action was in draft. In addition, the divisional strategy was also in draft.
- We were not assured leaders had oversight of clear and reliable midwifery and nurse staffing data; and we saw sickness rates and use of bank staff were high. Community caseloads, allowing for some changes in allowances and changes in NICE Guidance since 2009, exceeded the recommended ratio of 96 to 98 cases per WTE midwife. A high proportion of community clinics had been cancelled in the 12 months prior to inspection.
- Leaders did not always operate effective governance processes or manage performance effectively. The service did not always collect and collate reliable data; for example, we were not assured NICE red flag data was valid and reliable, and we observed some inaccuracies in other key data we reviewed. The frequency of perinatal morbidity and mortality meetings was not compliant with trust policy, the quality of women's and children's divisional meeting minutes varied, and action plans were not always sufficiently robust.
- Audit data showed improved compliance with medicine management on the central delivery suite, WHO safer surgery documentation checklist, and maternity record keeping was required.
- The time taken to investigate, and close complaints was not in line with the trust's complaints policy.

However:

- The service provided care and treatment based on national guidance and best practice. Staff completed and updated risk assessments for each woman and took action to remove or minimise risks. Staff identified and quickly acted upon women at risk of deterioration. The service made sure staff were competent for their roles.
- Staff understood how to protect women and children from abuse and the service worked well with other agencies to do so.
- Staff carried out daily and weekly safety checks of specialist and emergency equipment, and the service controlled infection risk well.
- Staff treated women with compassion and kindness, provided emotional support, respected their privacy and dignity, and took account of their individual needs. Staff supported women to make informed decisions about their care and treatment and followed national guidance to gain patients' consent.
- The service had an open culture where patients, their families and staff could raise concerns without fear. The service treated concerns and complaints seriously, investigated them and shared lessons learned with staff.

Is the service safe?

Requires improvement   

Our rating of safe stayed the same. We rated it as requires improvement because:

- The design, maintenance and use of facilities, premises and equipment did not always keep people safe. There was a risk of delayed access to the central delivery suite and theatres for women on the antenatal / postnatal ward. Senior managers also recognised safety risks associated with second (emergency) theatre availability.

Maternity

- Out of hours (duty) anaesthetist cover was shared with the intensive care unit; and we were not assured the anaesthetist could be immediately available to cover emergency work on delivery suite, without potentially placing patients at risk.
- We saw qualified nurse and midwife sickness rates and use of bank staff were high. Community caseloads, allowing for some changes in allowances and changes in NICE Guidance since 2009, exceeded the recommended ratio of 96 to 98 cases per WTE midwife.
- The service provided mandatory training in key skills to all staff; however, they did not make sure all staff completed it. Mandatory training compliance rates among medical staff were particularly low. The service had not conducted quarterly 'live' (unannounced) emergency skills and drills training, in line with trust policy. Completion rates for safeguarding adults' training were low among qualified nursing and midwifery staff. The service had not conducted a child abduction drill in the past three years.
- Audit data identified WHO safer surgery documentation checklist, maternity record keeping assurance, and management of medicines on the central delivery suite required improvement..
- The frequency of perinatal morbidity and mortality meetings was not compliant with trust policy.

However:

- Staff completed and updated risk assessments for each woman and took action to remove or minimise risks. Staff identified and quickly acted upon women at risk of deterioration.
- Staff understood how to protect women and children from abuse and the service worked well with other agencies to do so.
- The service controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean. Staff managed clinical waste well.

Is the service effective?

Good  ➡ ➡

Our rating of effective stayed the same. We rated it as good because:

- The service provided care and treatment based on national guidance and best practice. Managers checked to make sure staff followed guidance. Staff carried out daily and weekly safety checks of specialist and emergency equipment.
- Staff gave women enough food and drink to meet their needs and improve their health; monitored women regularly to see if they were in pain; and gave women practical support and advice to lead healthier lives.
- The service made sure staff were competent for their roles. Managers appraised midwifery and support staff work performance and held supervision meetings with them to provide support and development.
- Staff supported women to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. They knew how to support women who lacked capacity to make their own decisions or were experiencing mental ill health.
- Doctors, nurses and other healthcare professionals worked together as a team to benefit women. They supported each other to provide good care. Key services were available seven days a week to support timely care.

However:

Maternity

- The total stillbirth rate adjusted to exclude lethal abnormalities, and the stillbirth at term with low birth weight rate, were higher than regional averages.
- The proportion of women smoking at time of booking and delivery were higher than trust targets and regional averages.
- The appraisal rate for medical staff was low and did not meet trust target.
- Mental Capacity Act training compliance was low and did not meet trust targets.

Is the service caring?

Good   

Our rating of caring stayed the same. We rated it as good because:

- Staff treated women with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.
- Staff provided emotional support to women, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs.
- Staff supported women, families and carers to understand their condition and make decisions about their care and treatment.

Is the service responsive?

Requires improvement  

Our rating of responsive went down. We rated it as requires improvement because:

- People could not always access the service when they needed it and received the right care promptly; for example, data showed over 280 clinics had been cancelled in the community over a 12-month period.
- Audit data showed low compliance for offering an appointment within 2 weeks of referral if presenting at over 12 weeks of pregnancy.
- We were not assured treatment delay data (for example, regarding delayed inductions of labour) was always systematically reported and reliable. The service did not monitor waiting times for emergency c-sections.
- The time taken to investigate, and close complaints was not in line with the trust's complaints policy.

However:

- The service worked with others in the wider system and local organisations to plan care. Waiting times from referral to booking before 13 weeks, and arrangements to assess and monitor women at risk were in line with national standards.
- The service was inclusive and took account of women's individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.
- It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with staff.

Maternity

Is the service well-led?

Requires improvement   

Our rating of well-led stayed the same. We rated it as requires improvement because:

- Leaders and senior staff had the necessary experience and knowledge to lead effectively. However, there was an unstable leadership team structure. Staff expressed concerns about leadership stability and the implementation of new models of care; and described morale within the service had wavered.
- The service did not have an agreed vision for what it wanted to achieve and the strategy to turn it into action was in draft. In addition, the divisional strategy was in draft form.
- We were not assured leaders always operated effective governance processes. Medical staff reported they were not allocated adequate time for audit, governance and associated activities; and job plan reviews were ongoing to allocate time for these activities. In addition, we found the quality of divisional meeting minutes varied..
- The service did not always collect and collate reliable data; for example, we were not assured NICE red flag data was valid and reliable, and we observed some inaccuracies in other data we reviewed. We were not assured that the service had oversight of clear and reliable midwifery and nurse staffing data.
- Staff we spoke with were clear about their roles and accountabilities; but did not always have regular opportunities to meet, discuss and learn from the performance of the service. For example, the frequency of perinatal morbidity and mortality meetings was not compliant.

However:

- Leaders and teams identified and escalated key risks and issues and identified actions to reduce their impact. However, we were not assured that leaders always used systems to manage performance effectively. There were cross-site obstetrics and gynaecology governance meetings, and a lead governance midwife had recently been appointed.
- Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. The service had an open culture where patients, their families and staff could raise concerns without fear. Staff felt respected, supported and valued by colleagues and were focused on the needs of patients receiving care.
- Staff could find most key data they needed, in easily accessible formats, to understand performance, make decisions and improvements. However, leaders recognised improvements in data collection, reliability and accessibility were needed. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.
- Staff were committed to continually learning and improving services; and leaders encouraged innovation and participation in research.

Areas for improvement

We found areas for improvement in this service. See the Areas for Improvement section above.

Services for children and young people

Requires improvement  

Key facts and figures

At Scunthorpe general hospital, services for children and young people include a 16-bed inpatient ward with two high observation beds, a paediatric assessment unit, a 10-cot neonatal unit (comprising 10 cots, comprising of two intensive care cots, two high dependency care cots and six special care cots), a children's outpatient department, and a children's community nursing team.

The ward provides care for children and young people from 0-16 years of age and up to 18/19 years for those with complex needs.

At our last inspection we rated safe as requires improvement. Effective, caring, responsive and well-led were rated good.

We inspected services for children and young people 24 to 27 September 2019 as part of a comprehensive inspection and rated all five key questions. To help us make our judgements, we visited Disney ward, the operating theatres and recovery area, the paediatric assessment unit, neonatal unit and children's outpatients.

We looked at the environment and we spoke with two young people, three family members and five parents.

We spoke with 29 staff members including all grades of medical and nursing staff, non-registered nursing staff, and administrative staff at the hospital. We also interviewed the senior team for the service. We observed practice, staff interactions with patients and viewed fifteen sets of care records, which included prescription cards.

Before and after our inspection, we reviewed performance information about the trust and information provided to us by the trust.

Summary of this service

Our rating of this service went down. We rated it as requires improvement because:

- Some concerns we told the trust it must address at our last inspection in 2018 were not actioned by the leadership team. For example, staff did not receive the mental health training which we told the trust it must provide, following our last inspection in 2018.
- There was limited assurance staff consistently completed and updated mental health risk assessments for each child and young person with mental health issues and removed or minimised environmental risks. This was because they had not received appropriate mental health training.
- The service still did not always have enough nursing or medical staff with the right qualifications, skills, training and experience to comply with national guidance.
- Mandatory training compliance by medical staff had dropped since our last inspection in 2018.
- Local audits for sepsis, hand hygiene and paediatric early warning scores (PEWS) provided limited assurance. This was because sepsis tools were not always completed, departments did not consistently submit hand hygiene data and improvement was still required in clinical record keeping.
- Staff did not always keep detailed records of children and young people's care and treatment.

Services for children and young people

- Some staff we spoke with were unaware of the child abduction policy on the intranet and did not know when it was last tested.
- Mental capacity training data for medical staff indicated poor compliance.
- Senior leaders were not always visible.
- The service had a vision for what it wanted to achieve but no clear strategy to turn it into action.

However, we also found that:

- There was improved mandatory training compliance by nursing staff since our last inspection in 2018.
- Safeguarding training compliance had improved since our last inspection in 2018.
- Appraisal compliance had improved since our last inspection in 2018.
- The service provided care and treatment based on national guidance and evidence-based practice.
- Doctors, nurses and other healthcare professionals worked together as a team to benefit children, young people and their families.
- Staff treated children, young people and their families with compassion and kindness and respected their privacy and dignity.
- People could access the service when they needed it.
- Staff felt respected, supported and valued.
- All staff were committed to continually learning and improving services.

Is the service safe?

Requires improvement   

Our rating of safe stayed the same. We rated it as requires improvement because:

- Staff did not receive the mental health training which we told the trust it must provide, following our last inspection in 2018.
- There was limited assurance staff consistently completed and updated mental health risk assessments for each child and young person with mental health issues and removed or minimised environmental risks. This was because they had not received appropriate mental health training.
- The service did not always have enough nursing or medical staff with the right qualifications, skills, training and experience to comply with national guidance.
- Mandatory training compliance by medical staff had dropped since our last inspection in 2018.
- Staff did not always keep detailed records of children and young people's care and treatment.
- Local audits for sepsis provided limited assurance. This was because sepsis tools were not always completed and there was variable compliance.
- Some staff we spoke with were unaware of the child abduction policy on the intranet and did not know when it was last tested.

However, we also found that:

Services for children and young people

- The service provided mandatory training in key skills and made sure most staff completed it. There was improved mandatory training compliance by nursing staff since our last inspection in 2018.
- Staff understood how to protect children, young people and their families from abuse. Safeguarding training compliance had improved since last inspection in 2018.
- The service managed safety incidents well.

Is the service effective?

Good   

Our rating of effective stayed the same. We rated it as good because:

- The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance.
- Staff gave children, young people and their families enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. The service made adjustments for children, young people and their families' religious, cultural and other needs.
- Staff assessed and monitored children and young people regularly to see if they were in pain and gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.
- Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved generally good outcomes for children and young people.
- The service made sure staff were competent for their roles. Managers appraised staff work performance and held supervision meetings with them to provide support and development.
- Appraisal compliance rates had improved since our last inspection in 2018. All staff had either had an appraisal or were booked to receive one.
- Doctors, nurses and other healthcare professionals worked together as a team to benefit children, young people and their families. They supported each other to provide good care.
- Key services were available seven days a week to support timely care for children, young people and their families.
- Staff gave children, young people and their families practical support and advice to lead healthier lives.
- Staff supported children, young people and their families to make informed decisions about their care and treatment.

However, we also found that:

- Local audits for sepsis, hand hygiene and PEWS provided limited assurance. This was because sepsis tools were not always completed, departments did not consistently submit hand hygiene data and improvement was still required in clinical record keeping.
- Mental capacity training data for medical staff indicated poor compliance.

Is the service caring?

Good   

Services for children and young people

Our rating of caring stayed the same. We rated it as good because:

- Staff treated children, young people and their families with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.
- Staff provided emotional support to children, young people, families and carers to minimise their distress. They understood children and young people's personal, cultural and religious needs.
- Staff supported and involved children, young people and their families to understand their condition and make decisions about their care and treatment. They ensured a family centred approach.

Is the service responsive?

Good   

Our rating of responsive stayed the same. We rated it as good because:

- The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.
- The service was inclusive and mostly took account of children, young people and their families' individual needs and preferences. Staff made reasonable adjustments to help children, young people and their families access services. They coordinated care with other services and providers.
- People could access the service when they needed it. Waiting times from referral to treatment and arrangements to admit, treat and discharge children and young people were generally in line with national standards.
- The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included children, young people and their families in the investigation of their complaint.

However, we also found:

- Not all children on the ward were seen by a consultant within 14 hours, in accordance with national guidance.
- There were significant delays to resolution of complaints.
- We did not see information for those with sensory impairment. There were no flags in records or on the electronic booking system, which identified communication needs. This meant we were unsure how the trust assured itself the accessible information standard (AIS) was always met.

Is the service well-led?

Requires improvement  

Our rating of well-led went down. We rated it as requires improvement because:

- Some concerns we told the trust it must address at our last inspection in 2018 were still not actioned by the leadership team. This meant there was limited assurance the leadership team had oversight of the risks this would pose to children.
- For example, medical and nurse staffing was not compliant with national guidance and staff had not received mental health training in caring for children and young people with mental health needs.
- Senior leaders were not always visible.

Services for children and young people

- The service had a vision for what it wanted to achieve but no clear strategy to turn it into action.

However, we also found that:

- Leaders supported staff to develop their skills and take on more senior roles.
- Staff felt respected, supported and valued.

Areas for improvement

We found areas for improvement in this service. See the Areas for Improvement section above.

End of life care

Inadequate ● ↓

Key facts and figures

End of life (EOL) care encompasses all care given to patients who are approaching the end of their life and following death. It may be given on any ward or within any service in a trust. It includes aspects of essential nursing care, specialist palliative care, bereavement support and mortuary services. EOL care is provided across the organisation by nurses, consultants, health care assistants, mortuary and clerical staff across all directorates 365 days per year. Ward staff are supported by the third-party provider employing acute specialist Macmillan nurses. These staff assist in the delivery of end of life care across acute settings, through education, training, assessment and clinical availability. The team is led by a consultant in palliative medicine and consisted of five nurses a band 7 lead co-ordinator, two bereavement staff and an administrative role.

At our last inspection, we rated safe, effective, responsive and well led as requires improvement and caring as good.

We inspected end of life and palliative care services on 24-27 September 2019 as part of an announced comprehensive inspection of the whole trust due to it being in special measures. We carried out a further unannounced visit on the 10th October 2019.

As part of our inspection we observed daily practice and viewed eight sets of patient records and 'do not attempt cardiopulmonary resuscitation' (DNACPR) records and four prescription charts. During the inspection we visited surgical, medical and care of the elderly wards, and visited the mortuary, hospital chapel and bereavement team. We spoke to patients who were receiving end of life care and patients' relatives.

We spoke 22 members of staff across general wards, which included medical and nursing staff, the specialist palliative care team, the leadership team for end of life care, chaplaincy, mortuary and bereavement staff.

Summary of this service

Our rating of this service went down. We rated it as inadequate because:

- The service had not addressed many of the concerns from our last inspection, there were still areas where we told the trust they must improve that had not been actioned.
- At the last inspection in 2018 we told the trust it must ensure that sufficient numbers of palliative care staff are employed to provide care and treatment. At this inspection the service still did not have enough nursing or medical staff with the right qualifications, skills, training and experience to meet national guidance. Managers did not regularly review and adjust staffing levels and skill mix.
- The service did not have enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and provide the right care and treatment.
- Staff did not always keep detailed records of patients' care and treatment. Records were not consistently clear and up-to-date or easily available to all staff providing care.
- The service did not always provide care and treatment based on national guidance and evidence-based practice.
- There was very limited monitoring of patients care and treatment. Therefore, staff did not always monitor the effectiveness of care and treatment or use the findings to make improvements and achieve good outcomes for patients.

End of life care

- Preferred place of death was consistently documented for patients receiving end of life care.
- Staff did not consistently assess and monitor patients regularly to see if they were in pain and did not give pain relief in a timely way. Staff did not always complete documentation specific to end of life and palliative care.
- Staff did not support those unable to communicate using suitable assessment tools and give additional pain relief to ease pain.
- The service did not make sure staff were competent for their roles. Managers did not appraise staff's work performance and or hold supervision meetings with them to provide support and development.
- At the last inspection in 2018 we saw the trust was not providing a seven-day service. Key services were still not available seven days a week to support timely patient care.
- The service did not always take account of patients' individual needs and preferences. Multi faith facilities were not fully in place and access to chaplains was limited.
- The service did not consistently monitor performance to enable improvements for people at the end of their life. This included rapid discharge arrangements to enable people to meet their preferred place of care and death and referral to treatment times.
- There had been no improvement in the complaint's management for the service.
- There were insufficient leaders with the skills and abilities to run the service. They did not understand or manage the priorities and issues the service faced. Due to the small numbers of staff their visibility was limited. There was no clear leadership of the service and lines of accountability were blurred.
- Key senior management staff roles had been vacant for some time and remained unfilled at the time of inspection.
- There was no current local strategy or vision for the service.
- Staff working within the service told us they did not feel valued and respected. There was no sense that staff were fully engaged in making dying everyone's responsibility.
- There was a lack of governance structures in place with processes and systems of accountability to support a sustainable service.
- There was little understanding or management of risk. There was no risk register to identify that there was oversight of the current risks or that these had been escalated. For example, the lack of audit completion and staff vacancies. Therefore, risks were not shared within this speciality.
- Leaders and staff undertook limited engagement with patients and staff to plan and manage services.
- We saw limited evidence of any information to support learning, continuous improvement or innovation in the service.

However:

- The service provided mandatory training in key skills and most staff had completed it.
- Staff treat patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs. Staff provided emotional support to patients, families and carers to minimise their distress. Staff supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment.
- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so.

End of life care

Is the service safe?

Requires improvement   

Our rating of safe stayed the same. We rated it as requires improvement because:

- The design of the mortuary did not always keep people safe. Not all staff were trained to use the equipment in the mortuary.
- At the last inspection in 2018 we told the trust it must ensure that sufficient numbers of palliative care staff are employed to provide care and treatment. At this inspection the service still did not have enough nursing with the right qualifications, skills, training and experience to meet national guidance. Managers did not regularly review and adjust staffing levels and skill mix.
- The service did not have enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and provide the right care and treatment.
- Staff did not always keep detailed records of patients' care and treatment. Records were not consistently clear and up-to-date or easily available to all staff providing care.
- Staff did not consistently review patients' medicines.
- We did not see any written evidence of learning from incidents, changes in practice or wider dissemination across the whole specialty as a result. However, Staff delivering end of life and palliative care told us they understood their responsibilities regarding reporting incidents.
- The service did not use monitoring results well to improve safety.

However:

- The service provided mandatory training in key skills and most staff had completed it.
- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

Is the service effective?

Inadequate  

Our rating of effective went down. We rated it as inadequate because:

- The service did not always provide care and treatment based on national guidance and evidence-based practice.
- There was very limited monitoring of patients care and treatment. Therefore, staff did not always monitor the effectiveness of care and treatment or use the findings to make improvements and achieve good outcomes for patients.
- Staff did not consistently assess and monitor patients regularly to see if they were in pain and did not give pain relief in a timely way.
- Staff did not support those unable to communicate using suitable assessment tools and give additional pain relief to ease pain.
- Preferred place of death was not consistently documented for all patients receiving end of life care.

End of life care

- At the last inspection in 2018 we saw the trust was not providing a seven-day service. Key services were still not available seven days a week to support timely patient care.
- Medical staff did not receive and keep up to date with training in the Mental Capacity Act and Deprivation of Liberty Safeguards.

However:

- Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary.
- Staff gave patients practical support to help them live well until they died.

Is the service caring?

Good   

- Our rating of effective stayed the same. We rated it as good because:
- There was limited evidence of data. However, we saw staff treat patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.
- Staff provided emotional support to patients, families and carers to minimise their distress.
- Staff supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment.

Is the service responsive?

Requires improvement   

Our rating of effective stayed the same. We rated it as requires improvement because:

- The service did not always take account of patients' individual needs and preferences. Multi faith facilities were not fully in place and access to chaplains was limited.
- The trust did not consistently monitor performance to enable improvements for people at the end of their life. This included rapid discharge arrangements to enable people to meet their preferred place of care and death and referral to treatment times.
- There had been no improvement in the services management of complaints. Complaints were not managed in accordance with trust policy or shared with colleagues to drive improvement.
- Information leaflets regarding death and bereavement were only available in English.

However:

- Equipment loan services were available seven days a week, with community equipment loans accessible to ward staff.
- Bereavement staff at SGH offered a one stop shop arrangements for families visiting to collect death certificates.

End of life care

Is the service well-led?

Inadequate ● ↓

Our rating of well-led went down. We rated it as inadequate because:

- There were insufficient leaders with the skills and abilities to run the service. They did not understand or manage the priorities and issues the service faced. Due to the small numbers of staff their visibility was limited. There was no clear leadership of the service and lines of accountability were blurred.
- Actions we told the trust it must take to address concerns following our last inspection, in 2018, had not been completed.
- Key senior management staff roles had been vacant for some time and remained unfilled at the time of inspection.
- There was no current local strategy or vision for the service.
- Staff working within the service told us they did not feel valued and respected. There was no sense that staff were fully engaged in making dying everyone's responsibility.
- There was a lack of governance structures in place with processes and systems of accountability to support a sustainable service.
- Managers of the service did not always complete internal audits. Those which were completed were not progressed through the monitoring of effective action plans.
- There was little understanding or management of risk. There was no risk register to identify that there was oversight of the current risks or that these had been escalated. For example, the lack of audit completion and staff vacancies. Therefore, risks were not shared within this speciality.
- Leaders and staff undertook limited engagement with patients and staff to plan and manage services.
- We saw limited evidence of any information to support learning, continuous improvement or innovation in the service.

However:

- Staff held the palliative care consultant in high regard and felt the service sustainability was due to this individual's dedication.

Areas for improvement

We found areas for improvement in this service. See the Areas for Improvement section above.

Outpatients

Inadequate   

Key facts and figures

Outpatient services were provided on all three hospital sites in dedicated outpatient areas. There were a number of out-reach clinics that take place outside of the main hospital sites. The majority of clinics were provided during core hours; however, a small number of evening and weekend clinics took place.

Outpatients and pathology were part of the clinical support services division. Clinical Support Services Division role is to provide nursing staff, administration support for receptions and all of the health records functionality. A range of clinics were provided by outpatients such as surgery outpatients, medicine outpatients, ophthalmology, respiratory, diabetes, urology, neurology and ear, nose and throat.

Waiting lists for each speciality are held by that speciality. The method of delivery is predominantly face to face, however, the trust were beginning to review patients via telephone clinics.

During the inspection we visited main outpatients including ophthalmology outpatients.

Our inspection was announced (staff knew we were coming) to enable us to observe routine activity.

During the inspection we spoke with 20 staff, 13 patients and reviewed 14 records.

Total number of first and follow up attendances compared to England

The trust had 374,436 first and follow up outpatient attendances from March 2018 to February 2019.

(Source: Hospital Episode Statistics - HES Outpatients)

Number of appointments by site (including DNAs and cancellations)

The following information shows the number of outpatient appointments by site, a total for the trust and the total for England, from March 2018 to February 2019.

Diana, Princess of Wales Hospital - 213,297

Scunthorpe General Hospital - 159,590

Goole and District Hospital - 31,725

This trust - 404,612

England total - 109,330,519

(Source: Hospital Episode Statistics)

Summary of this service

Our rating of this service stayed the same. We rated it as inadequate because:

- The trust had identified incidents in 2018 and 2019 where patients had come to harm due to delays in receiving appointments in out-patients. We had significant concerns regarding this and requested further information from the

Outpatients

trust on what it was doing to limit risk in a section 31 “letter of intent to seek further clarification from the trust”. The trust provided a response to this. CQC continue to have concerns about the risks of harm and potential harm to patients when waiting times remain lengthy. However, we were assured that the trust had put in place oversight mechanisms and processes to limit the risks.

- Following the inspection, the trust provided more information which showed they had revised the inclusion criteria for patients to be added to the clinical harm review in ophthalmology to include any delay that exceeded the speciality/department risk stratification criteria. For example, in September 2019, this new risk stratification criteria had identified 83 patients to be added to the clinical harm review. Of these 83 patients, 37 patients had been seen and assessed for harm and the trust highlighted there was no harm in 24 of these patients, there was low harm in ten patients and one moderate harm and two severe harm. Out of the 83 patients identified, the remaining 46 patients were due to have a clinical harm review in November 2019.
- Whilst the trust had implemented clinical validation to help ensure patients were seen in order of clinical need, there remained risk in some waiting lists due to the volume of patients on the waiting list and the service not meeting the operational standard for patients receiving their first treatment within 62 days of an urgent GP referral for a suspected cancer diagnosis. This was an ongoing concern since our previous inspection. The trust provided information after the inspection stating they were taking steps to address the challenges with cancer performance in accordance with the trust’s performance management framework.
- We did not see evidence of safety checklists being used in any areas other than in ophthalmology.
- Staff did not consistently tell us they had received shared learning from incidents.
- Although records were now stored securely, which was an improvement since our last inspection, records were not always timed and staff did not always provide their role or designation. Written notes were not consistently legible. These concerns were ongoing since our previous inspection.
- Although the oversight of waiting lists and backlogs had improved, the July 2019 board papers showed there remained 33,673 overdue outpatient review appointments in May 2019. Overall there had been improvements with the referral to treatment indicators, however there remained specialties which did not always achieve the referral to treatment indicators.
- From June 2018 to May 2019 the trust’s referral to treatment time (RTT) for non-admitted pathways has been worse than the England overall performance. The latest figures for May 2019, showed 78.7% of this group of patients were treated within 18 weeks versus the England average of 87.6%.
- From June 2018 to May 2019 the trust’s referral to treatment time (RTT) for incomplete pathways has been worse the England overall performance, although there has been an improving trend from January to May 2019. The latest figures for May 2019 showed 77.8% of patients still waiting for treatment had been waiting for less than 18 weeks, versus the England average of 86.4%.
- From June 2018 to June 2019, the trust received 134 complaints in relation to outpatients at the trust (27.6% of total complaints received by the trust). 66 complaints were still open and under investigation or partially upheld with no closed date. Of the 68 complaints that were closed, the trust took an average of 82.2 working days to investigate and close complaints. This was not in line with their complaints policy, which states complaints should be closed within 60 working days.
- From March 2018 to February 2019, the did not attend rate for Diana, Princess of Wales Hospital was higher (worse) than the England average. At the previous inspection, there was no strategy in place and although the trust had developed a strategy and provided the draft strategy for outpatients, this was still a draft version.

However, we also found:

Outpatients

- The service provided mandatory training in key skills to all staff and made sure everyone completed it. Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.
- The service controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean. Staff managed clinical waste well.
- The service had enough nursing and support staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed staffing levels and skill mix and gave bank staff a full induction. The service used systems and processes to safely prescribe, administer, record and store medicines.
- Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care. Staff gave patients practical support and advice to lead healthier lives. Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs. Staff provided emotional support to patients, families and carers to minimise their distress. Patients were given contact details for specialist nurses to contact with any worries or questions.
- Staff supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment. Patients we spoke with gave positive feedback about their care and treatment in outpatients at this hospital.
- The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. Leaders and teams used systems to manage performance.
- There had been improvement in some areas and improved oversight and governance regarding the challenges across outpatient services. The services had implemented procedures to support the work regarding the challenges in outpatients, for example outpatient leaders monitored performance through performance reports and regular meetings.

Is the service safe?

Inadequate ● ↓

Our rating of safe went down. We rated it as inadequate because:

- The trust had identified incidents in 2018 and 2019 where patients had come to harm due to delays in receiving appointments in out-patients. We had significant concerns regarding this and requested further information from the trust on what it was doing to limit risk in a section 31 "letter of intent to seek further clarification from the trust". The trust provided a response to this. CQC continue to have concerns about the risks of harm and potential harm to patients when waiting times remain lengthy. However, we were assured that the trust had put in place oversight mechanisms and processes to limit the risks.
- After the inspection, the trust told us they had revised the inclusion criteria for patients to be added to the clinical harm review in ophthalmology to include any delay that exceeded the speciality/department risk stratification criteria. For example, in September 2019, this new risk stratification criteria had identified 83 patients to be added to

Outpatients

the clinical harm review. Of these 83 patients, 37 patients had been seen and assessed for harm and the trust highlighted there was no harm in 24 of these patients, there was low harm in ten patients and one moderate harm and two severe harm. Out of the 83 patients identified, the remaining 46 patients were due to have a clinical harm review in November 2019.

- Whilst the trust had implemented clinical validation to help ensure patients were seen in order of clinical need, there remained significant risk in some waiting lists due to the volume of patients on the waiting list and the service not meeting the operational standard for patients receiving their first treatment within 62 days of an urgent GP referral for a suspected cancer diagnosis. This was an ongoing concern since our previous inspection.
- Staff did not consistently tell us they had received shared learning from incidents.
- We did not see evidence of safety checklists being used in any areas other than in ophthalmology.
- Although records were now stored securely, which was an improvement since our last inspection, records were not always timed and staff did not always provide their role or designation. Written notes were not consistently legible. These concerns were ongoing since our previous inspection.

However:

- The service provided mandatory training in key skills to all staff and made sure everyone completed it. Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.
- The service controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean. Staff managed clinical waste well.
- The service had enough nursing and support staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed staffing levels and skill mix and gave bank staff a full induction. The service used systems and processes to safely prescribe, administer, record and store medicines.

Is the service effective?

Not sufficient evidence to rate ●

We do not rate effective in outpatients, however we found:

- The service provided care and treatment based on national guidance and evidence of its effectiveness. Managers checked to make sure staff followed guidance.
- Staff gave patients enough food and drink to meet their needs and improve their health.
- Staff monitored the effectiveness of care and treatment.
- The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development.
- Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.
- Staff gave patients practical support and advice to lead healthier lives.
- Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent.

Outpatients

Is the service caring?

Good ● → ←

Our rating of caring stayed the same. We rated it as good because:

- Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.
- Staff provided emotional support to patients, families and carers to minimise their distress. Patients were given contact details for specialist nurses to contact with any worries or questions.
- Staff supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment.
- All of the patients we spoke with gave positive feedback about their care and treatment in outpatients at this hospital.
- In August 2019, 94% of people who completed the Friends and Family Test (FFT) were extremely likely or likely to recommend this outpatients department to their family and friends.

Is the service responsive?

Inadequate ● → ←

Our rating of responsive stayed the same. We rated it as inadequate because:

- Although the oversight of waiting lists and backlogs had improved, the July 2019 board papers showed there remained 33,673 overdue outpatient review appointments in May 2019.
- There remained challenges with the services meeting the 62-day cancer waiting time targets. The trust was performing worse than the 85% operational standard for patients receiving their first treatment within 62 days of an urgent GP referral. This was an issue at the previous inspection. The trust provided further information stating that they were aware of the need to improve and had taken additional actions to address this such as bringing in external clinical expertise to work alongside clinicians to change and improve decision making.
- Overall referral treatment times had improved in some specialities since our May 2018 inspection. The trust also provided some information which showed a reduction in patients waiting more than 40+ weeks from 1503 to 311, however there remained challenges within some specialities.
- From June 2018 to May 2019 the trust's referral to treatment time (RTT) for non-admitted pathways has been worse than the England overall performance. The latest figures for May 2019, showed 78.7% of this group of patients were treated within 18 weeks versus the England average of 87.6%.
- From June 2018 to May 2019 the trust's referral to treatment time (RTT) for incomplete pathways has been worse the England overall performance, although there has been an improving trend from January to May 2019. The latest figures for May 2019 showed 77.8% of patients still waiting for treatment had been waiting for less than 18 weeks, versus the England average of 86.4%.

Outpatients

- From June 2018 to June 2019, the trust received 134 complaints in relation to outpatients at the trust (27.6% of total complaints received by the trust). 66 complaints were still open and under investigation or partially upheld with no closed date. Of the 68 complaints that were closed, the trust took an average of 82.2 working days to investigate and close complaints. This was not in line with their complaints policy, which states complaints should be closed within 60 working days.
- From March 2018 to February 2019, the did not attend rate for Diana, Princess of Wales Hospital was higher (worse) than the England average.

However:

- The service worked with others in the wider system and local organisations to plan care.
- The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services.
- The trust was performing better than the 93% operational standard for people being seen within two weeks of an urgent GP referral.
- The trust was performing better than the 96% operational standard for patients waiting less than 31 days before receiving their first treatment following a diagnosis (decision to treat).

Is the service well-led?

Requires improvement ● ↑

Our rating of well-led improved. We rated it as requires improvement because:

- Although there had been improvements in the governance and oversight of waiting lists and backlogs. There remained challenges with the backlog of overdue patients waiting for appointments, referral to treatment indicators and the 62-day cancer waiting times remained a challenge. The trust provided information after the inspection stating they were taking steps to address the challenges with cancer performance in accordance with the trust's performance management framework.
- There had been incidents of patient harm which related to the delay in treatment across the specialties, for example in ophthalmology outpatients.
- At the previous inspection, there was no strategy in place and although the trust had developed a strategy and provided the draft strategy for outpatients, this was still a draft version.
- There was limited evidence of innovation across the outpatient departments.

However:

- The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. Leaders and teams used systems to manage performance.
- There had been improvement in some areas and improved oversight and governance regarding the challenges across outpatient services. The services had implemented procedures to support the work regarding the challenges in outpatients, for example outpatient leaders monitored performance through performance reports and regular meetings.

Outpatients

- The service collected data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Leaders and staff actively and openly engaged with patients.

Areas for improvement

We found areas for improvement in this service. See the Areas for Improvement section above.

Diagnostic imaging

Inadequate ● ↓

Key facts and figures

Radiology is provided across the three main sites: DPOW site provides X-ray, fluoroscopy, CT, MRI, ultrasound, breast imaging and nuclear medicine services; SGH provides X-ray, fluoroscopy, CT, MRI and ultrasound; and Goole and District Hospital provides X-ray, fluoroscopy, and ultrasound with some mobile CT & MRI provision at this site.

Most services are provided across seven days, the exceptions being breast imaging and nuclear medicine which are five-day services. Emergency services are provided 24/7 for X-ray and CT at the two main sites. There is some community ultrasound provision, in GP surgeries across the region.

Audiology services are provided from all three hospital sites, as well as in many community settings. Physiological measurement investigations are undertaken on the two main hospital sites by a team based at DPOW.

(Source: Routine Provider Information Request (RPIR) – AC1. Context acute)

Summary of this service

Our rating of this service went down. We rated it as inadequate because:

- Patients could not always access the service when they needed it. Waiting and result reporting times were not in line with national standards.
- There had been incidents where patients had come to harm due to delays in reporting results. We had significant concerns regarding this and after the inspection, the Care Quality Commission completed a section 31 letter of intent to seek further clarification from the trust.
- Safety was not a sufficient priority. Although there was measurement and monitoring of safety performance, there was a limited response leading to unacceptable levels of incidents and potential harm.
- There had been a lack of pace to address the backlogs and therefore there were concerns that incidents and near misses were not recognised which had caused harm and put patients at risk of harm or potential harm.
- From May 2018 to April 2019, the percentage of patients waiting more than six weeks to see a clinician (12%) was higher than the England average (3%).
- Substantial, ongoing and frequent staff shortages increased risks to people who used services.
- Although, the trust had systems for identifying risks in place, opportunities to prevent and minimise harm were missed.
- Since our last inspection in 2018, the backlog in unreported results had increased from 5,364 examinations (3,686 patients) to 10,701 examinations (7,045 patients) in July 2019.
- The contract with the external reporting company to address the backlog had been put in place in August 2019. This delay increased the potential risk of harm to patients.
- At the time of inspection, the overall backlog in unreported results across all modalities was 7,942 delays (4,719 patients).
- Following inspection, the initial trajectory for clearing the backlog in unreported results had changed and extended, increasing the risk of potential and actual harm to patients still within the backlog of unreported and delayed results.

Diagnostic imaging

- There were trust wide shortages of radiologists. This impacted on reporting rates across the trust, including Scunthorpe General Hospital.
- Although there was some resistance from existing radiologists to supporting the long-term development of radiographers' capacity to report on results, the expansion of plain film reporting to chest and abdomen was supported and the Trust had also put in place other initiatives to improve their reporting capacity.
- From June 2018 to June 2019, the trust received 19 complaints in relation to diagnostic imaging (3.9% of total complaints received by the trust). Nine complaints were still open and under investigation or partially upheld with no closed date. Of the closed complaints, the trust took an average of 67.8 working days to investigate and close. This was not in line with their complaints policy, which states complaints should be completed within 60 working days.
- Local rules were not clear as to which procedures could be requested by individual clinicians.
- Local dosage reference levels (DRLs) were not in place or displayed in all appropriate rooms.
- There were inconsistencies within the electronic records we reviewed. Of the records we checked over half were missing key documents such as recording of consent to treatment.
- A finalised divisional strategy was not in place and had been developed to draft stage only.

However:

- The service provided mandatory training in key skills to all staff and made sure everyone completed it.
- The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use equipment.
- Staff we spoke with were aware of their responsibilities in relation to duty of candour.
- The service provided care and treatment based on national guidance and evidence of its effectiveness. Managers checked to make sure staff followed guidance.
- Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.
- In August 2019, 86% of people who completed the Friends and Family Test (FFT) were extremely likely or likely to recommend this service to their family and friends.
- The service planned and provided care in a way that met the needs of local people and the communities served.
- The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services.

Is the service safe?

Inadequate  

Our rating of safe went down. We rated it as inadequate because:

- At the time of inspection, the overall backlog in unreported results across all modalities was 7,942 delays (4,719 patients).

Diagnostic imaging

- There had been incidents where patients had come to harm due to delays in reporting results. We had significant concerns regarding this and after the inspection, the Care Quality Commission completed a section 31 letter of intent to seek further clarification from the trust.
- Following inspection, the initial trajectory for clearing the backlog in unreported results had changed and extended, increasing the risk of potential and actual harm to patients still within the backlog of unreported and delayed results.
- Safety was not a sufficient priority. Although there was measurement and monitoring of safety performance, there was a limited response leading to unacceptable levels of incidents and potential harm.
- There was insufficient numbers of medical staff.
- There had been a lack of pace to address the backlogs and therefore there were concerns that incidents and near misses were not recognised which had caused harm and put patients at risk of harm or potential harm.
- Local rules were not clear as to which procedures could be requested by individual clinicians.
- Local dosage reference levels (DRLs) were not in place or displayed in scanning rooms.
- Although there was some resistance from existing radiologists to supporting the long-term development of radiographers' capacity to report on results, the expansion of plain film reporting to chest and abdomen was supported and the Trust had also put in place other initiatives to improve their reporting capacity.
- There was inconsistency of record keeping at Scunthorpe General Hospital. Of the records we checked over half were missing key documents such as recording of consent to treatment.
- We found that sharps bins were not always dated appropriately.

However, we also found:

- The service provided mandatory training in key skills to all staff and made sure everyone completed it.
- The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use equipment.
- Staff we spoke with were aware of their responsibilities in relation to duty of candour.

Is the service effective?

Not sufficient evidence to rate



We do not rate effective in diagnostic imaging, however we found:

- The service provided care and treatment based on national guidance and evidence of its effectiveness. Managers checked to make sure staff followed guidance.
- Staff monitored the effectiveness of care and treatment.
- Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.
- Staff gave patients practical support and advice to lead healthier lives.
- The service made sure staff were competent for their roles.

Diagnostic imaging

Is the service caring?

Good ● → ←

Our rating of caring stayed the same. We rated it as good because:

- Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.
- Staff provided emotional support to patients, families and carers to minimise their distress.
- Staff supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment.
- All patients gave positive feedback about their care and treatment in outpatients at this hospital.
- In August 2019, 86% of people who completed the Friends and Family Test (FFT) were extremely likely or likely to recommend this service to their family and friends.

Is the service responsive?

Inadequate ● ↓

Our rating of responsive went down. We rated it as inadequate because:

- The service did not provide care in a way that met the needs of local people and the communities served. However the department was accessible.
- Patients could not always access the service when they needed it. Waiting and result reporting times were not in line with national standards.
- From May 2018 to April 2019, the percentage of patients waiting more than six weeks to see a clinician (12%) was higher than the England average (3%).
- Substantial, ongoing and frequent staff shortages increased risks to people who used services.
- Since our last inspection in 2018, the backlog in unreported results had increased from 5364 examinations (3686 patients) to 10701 examinations (7045 patients) in July 2019.
- The contract with the external reporting company to address the backlog had been put in place in August 2019. This delay increased the potential risk of harm to patients.
- Following inspection, the initial trajectory for clearing the backlog in unreported results had changed and extended, increasing the risk of potential and actual harm to patients still within the backlog of unreported and delayed results.
- From June 2018 to June 2019, the trust received 19 complaints in relation to diagnostic imaging (3.9% of total complaints received by the trust). Nine complaints were still open and under investigation or partially upheld with no closed date. Of the closed complaints, the trust took an average of 67.8 working days to investigate and close. This was not in line with their complaints policy, which states complaints should be completed within 60 working days.

However:

- The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services.

Diagnostic imaging

- The trust were taking actions to address the backlogs and had reduced these by 47% by November 2019.

Is the service well-led?

Requires improvement ● ➡ ➡

Our rating of well-led stayed the same. We rated it as requires improvement because:

- At the time of inspection, the overall backlog was 7,942 delays in reporting results affecting 4,719 patients.
- Although there was a governance structure in place monitoring waiting lists for treatments and delays in reporting results, the delay in finalising the contract with the external reporting company had increased the potential risk of harm to patients.
- Although we saw evidence that the trust was actively assessing and monitoring risks to patients, we were not assured that these were managed in a timely way to prevent or minimise harm.
- Although, the trust had systems for identifying risks in place, opportunities to prevent and minimise harm were missed.
- At the previous inspection, a strategy was not in place and although the division had developed a strategy, this had not been finalised.
- Although there was some resistance from existing radiologists to supporting the long-term development of radiographers' capacity to report on results, the expansion of plain film reporting to chest and abdomen was supported and the Trust had also put in place other initiatives to improve their reporting capacity.

However

- Leaders and staff engaged with patients and most staff felt respected, supported and valued.

Areas for improvement

We found areas for improvement in this service. See the Areas for Improvement section above.

Community health services

Background to community health services

Northern Lincolnshire and Goole NHS Foundation Trust provides a range of hospital based and community services to a population of more than 400,000 people across North and North East Lincolnshire and East Riding of Yorkshire.

We inspected all community services provided by the trust, this included community health services for adults, community end of life care and community dental services. For more information, please see the background to the trust section.

Summary of community health services

Requires improvement → ←

Our ratings improved for community health services for adults. We rated safe, effective, caring and well led as good with responsive being rated as requires improvement. Both safe and well led ratings improved.

Our ratings improved for community dental services. We rated safe, effective, caring, responsive and well led as good. Both safe and well led ratings improved.

Our ratings went down for community end of life services. We rated safe, effective, responsive and well led as requires improvement which all went down. We rated caring as good which stayed the same.

Community end of life care

Requires improvement  

Key facts and figures

End of life (EOL) care encompasses all care given to patients who are approaching the end of their life and following death. It may be given within any service in a trust including delivering care in patients' homes. It includes aspects of essential nursing care, specialist palliative care, bereavement support and mortuary services. EOL care is provided across the organisation by nurses, consultants, health care assistants, mortuary and clerical staff across all directorates 365 days per year. Ward staff are supported by the acute specialist Macmillan nurses who assisted staff to deliver end of life care across acute settings, through education, training, assessment and clinical availability. The team is led by a consultant in palliative medicine.

The community end of life team comprised of a consultant in palliative medicine, a clinical co-ordinator, Macmillan specialist nurses and the Macmillan home care team supported by management and administration roles. In the last 12 months, the team supported 460 patients.

At our last inspection we rated safe, effective, responsive and well led as good, giving an overall rating for this service of good.

We inspected end of life and palliative care services in the community on 24-27 September 2019. Our inspection was announced, and staff knew we were coming to enable us to observe routine activity.

During this inspection we visited both of the Macmillan team bases and visited patients in their homes to observe care given by the team and spoke to patients and their families about their care.

We spoke with nine members of staff including senior managers, the specialist palliative care team and Macmillan home care team members. We looked at seven care records of patients receiving either palliative or end of life care. We spoke with three patients and four of their family members. We reviewed five do not attempt cardiopulmonary resuscitation forms.

Summary of this service

Our rating of this service went down. We rated it as requires improvement because:

- The service did not have enough staff to meet national guidance. Key management roles were unfilled.
- The service had not maintained its performance since our last inspection. For example, outcome measurement and local audit work had not taken place for the previous nine months, so leaders did not know how effective their service was.
- Staff knew how to report incidents but these were not discussed systematically and team meeting minutes did not show evidence of discussion or learning from incidents.
- There was no organisational strategy or vision.
- Safeguarding and mandatory training rates were low, and below the trust target.
- A specialist end of life service was not available 24 hours a day, seven days a week.
- There was a lack of governance systems to oversee safety, performance and risk within the service.

Community end of life care

- Staff did not receive regular supervision, or in the case of the home care team, any supervision. Appraisal rates were below trust target which was something we had told the trust they must improve at our last inspection.
- Complaints were not always acted upon in line with trust policy.
- Rates of key training such as the use of syringe drivers to deliver medicine to people receiving end of life care, and mental capacity act training, were low, and where applicable, below trust targets.
- Shortages of key equipment meant that electronic records were not always updated contemporaneously, and staff could not always access the systems they needed when working away from their base.

However:

- Staff provided effective emotional support to patients and their families and feedback confirmed this.
- Equipment was clean and available for use when needed. Staff working in patients' homes used appropriate techniques and personal protection equipment to minimise the risk of spread of infection.
- Staff worked well with other partners and teams both within and outside the trust.
- There had been no complaints about the service in the last 12 months.
- Staff felt respected, supported and valued, and were focussed on the needs of patients receiving care.
- Mandatory training rates were good and staff met the target for eight of nine training modules.

Is the service safe?

Requires improvement  

Our rating of safe went down. We rated it as requires improvement because:

- The service did not always have enough nursing, medical and support staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and provide the right care and treatment. At nights and weekends, nurse staffing levels were low and there was no access to specialist nurse support. There was only 15 hours of consultant time per week.
- Shortages of key equipment meant that electronic records were not always updated contemporaneously, and staff could not always access the systems they needed when working away from their base.
- Staff recognised and reported incidents and near misses. Team meetings were infrequent and informal and we did not see any written evidence of learning from incidents, changes in practice or wider dissemination across the whole specialty as a result.
- Safeguarding training levels were below trust target and had deteriorated since our last inspection. We were therefore not assured that staff had the right skills and training to keep people safe.

However:

- The service provided mandatory training in key skills to all staff and made sure everyone completed it. Nursing staff received and kept up to date with their mandatory training.
- The service controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.

Community end of life care

- Staff responded well to patient risk and used systems and processes to safely prescribe, record and store medicines. Risk assessments considered patients who were deteriorating and in the last days or hours of their life.

Is the service effective?

Requires improvement  

Our rating of effective went down. We rated it as requires improvement because:

- The service provided care and treatment which was not always based on national guidance and evidence based practice. The trust was not meeting national recommendations for the early identification of patients at the end of life or meeting guidelines for the correct levels of service.
- Staff did not routinely monitor the effectiveness of care and treatment. There were no local service audits, so managers could not use these to make improvements and achieve good outcomes for patients. The trust participated in national audits, but no local audits had been conducted for the previous nine months.
- The service did not always make sure that staff were competent for their roles. Managers did not regularly appraise staff's work performance and did not hold supervision meetings with them to provide support and development.
- Key services were not available seven days a week to support timely patient care. There was no evening specialist cover.
- The team was not meeting trust targets for the completion of mental capacity training.
- The service was not working towards an independent accreditation standard such as the Gold Standard Framework.

However:

- Staff gave patients enough food and drink to meet their needs. They used special feeding and hydration techniques when necessary.
- Staff assessed and monitored patients regularly to see if they were in pain and gave pain relief in a timely way.
- Doctors, nurses and other healthcare professionals worked together as a team to benefit patients.
- Staff gave patients practical support to help them live well until they died.

Is the service caring?

Good   

Our rating of caring stayed the same. We rated it as good because:

- Staff treated patients with compassion and kindness, respected their privacy and dignity and took account of their individual needs.
- Patients said staff treated them well and with kindness.
- Staff understood and respected the individual needs of each patient and showed understanding and a non-judgemental attitude.
- Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs.

Community end of life care

- Staff understood the emotional and social impact that a person's care, treatment or condition had on their wellbeing and on those close to them.
- Staff supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment.
- Patients and their families could give feedback on the service and their treatment and staff supported them to do this.

However:

- The most recent bereavement survey was completed over a year ago and no further surveys had been implemented.

Is the service responsive?

Requires improvement ● ↓

Our rating of responsive stayed the same. We rated it as requires improvement because:

- The service took a limited approach to planning and providing care in a way that met the needs of local people.
- Information leaflets regarding death and bereavement were only available in English.
- Patients could normally, but not always, access the specialist palliative care service when they needed it.

However:

- The service took account of some patients' individual needs and preferences. Staff made some reasonable adjustments to help patients access services. They coordinated care with other services and providers.
- The service had not received any formal complaints in the previous 12 months.

Is the service well-led?

Requires improvement ● ↓

Our rating of well-led went down. We rated it as requires improvement because:

- Leaders did not always have sufficient skills and abilities to run the service. Some key posts remained vacant, and there was no clear leadership structure 'from ward to board' as the wider team still sat within four different directorates at the time of our inspection.
- The service did not have a vision for what it wanted to achieve and no published strategy to turn it into action.
- Leaders did not operate effective governance processes throughout the service or with partner organisations. There was no operational or governance resource associated with the team. Few trust end of life strategy meetings had taken place and membership had been variable.
- There was no one separate risk register for the entirety of the end of life team, and although all community risks were stored within the community directorate risk register, this meant that there was no oversight of the total risk across the end of life team.
- The service did not always collect data and did not routinely analyse it. Staff could not find the data they needed to understand performance, make decisions and improvements. There was no monitoring of individual nurse specialist caseloads by managers who did not know what the total capacity of the team was.

Community end of life care

However:

- Local leaders were visible and approachable, and staff spoke highly of them.
- Team managers had developed bespoke competency packages and one-off training days to support staff to develop their skills. Staff were encouraged and supported to take on more senior roles.
- Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service had an open culture where staff could raise concerns without fear.
- Leaders and staff actively and openly engaged with patients, staff, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.

Areas for improvement

We found areas for improvement in this service. See the Areas for Improvement section above.

Community health services for adults

Good  

Key facts and figures

Northern Lincolnshire and Goole NHS Foundation Trust provided a wide range of adult community and therapy services to a population of more than 350,000 people across North and North East Lincolnshire and the East Riding of Yorkshire.

Community health services for adults sat within the Division of Community and Therapy Services and was established as part of the “Fit for the Future” consultation in April 2011. It has a budget of around £27 million and has approximately 700 whole time equivalent staff.

Community services for adults were provided at around 50 locations, which carried out 28 specialties for this core service. The regularity of clinics ranged from once a month to 56 per month at some locations.

The integrated community adult teams (district nursing, physiotherapy and occupational therapy) were managed in North Lincolnshire in three geographical networks: east, west and south. The teams were co-located with social service colleagues.

Therapy services were provided across both North Lincolnshire and North East Lincolnshire. The service also provided community equipment via two equipment stores, one in Grimsby and one in Scunthorpe.

We carried out a fully comprehensive inspection of this core service in September 2019 and inspected all five domains.

Our inspection was part of an announced comprehensive inspection of the whole trust, this was due to it being in special measures.

At this inspection we visited;

- The South Care Network
- The West Care Network
- The East Care Network
- The Complex Care Matrons
- The Single Point of Access Team
- The Unscheduled Care Team
- The Ironstone Centre
- The Community Equipment Store in Scunthorpe
- The Community Therapy Team base in North East Lincolnshire

During our inspection, we spoke with 35 members of staff including, administration staff, nurses, technicians, managers, therapists and nursing and therapy assistants. We observed staff providing care in clinics and in patient's homes. We spoke with 10 patients and relatives and looked at 10 patient records. We also reviewed performance information from, and about, the trust.

Community health services for adults

This service was previously inspected in May 2018 as part of a comprehensive inspection and was rated as requires improvement overall. We rated safe, responsive and well led as requires improvement and caring and effective as good.

At the last inspection we told the service they must make the following improvements;

- must ensure that there are sufficient qualified, competent, skilled and experienced staff to meet the needs of people using the services.
- must ensure that all non-medical prescribers receive regular supervision from a Designated Medical Practitioner (DMP) as per trust policy. Supervision must include regular monitoring, review and discussion of their prescribing history to ensure this is safe and effective.
- must ensure that prescription pad use and storage is audited for all non-medical prescribers.
- must ensure that all staff receive an annual appraisal and regular supervision in line with trust policy to provide them with support and enable staff access to the training and development they need to improve services to patients.
- must ensure that patients are able to access services in a timely way, especially in the continence service, the unscheduled care team and therapy services.
- must ensure that community nurses are using a recognised and effective risk assessment tool to assess the risk of pressure damage to patients.
- must ensure that staff receive feedback on incidents and lessons learnt are shared across the wider teams.
- must ensure that lessons learnt from complaints are shared with all staff.
- must ensure that there is a robust strategy for community health services for adults, developed with involvement from staff, patients, and key groups representing the local community.

We also told them they should make improvements in the following areas;

- should ensure that when staff transport used sharps bins in vehicles they secure the temporary closure and store the bins in a rigid container as per trust policy.
- should ensure that patient outcomes are monitored, audited and where possible benchmarked to provide evidence of effectiveness and to drive service improvement.
- should ensure that all staff are aware of and use the template to record the information and communication needs of people with a disability or sensory loss in order to meet the accessible information standard.

Summary of this service

Our rating of this service improved. We rated it as good because:

- The service had made improvements to many areas of concern we identified at the last inspection.
- The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. This was an improvement since our last inspection.

Community health services for adults

- The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.
- The service used systems and processes to safely prescribe, administer, record and store medicines. The division had introduced a new pathway for prescribing governance and non-medical prescribers were now given the opportunity to discuss their prescribing history and report during supervision. Prescription pad use and storage was audited for all non-medical prescribers.
- The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development. Staff told us that supervision had improved since the last inspection.
- Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs. Staff provided emotional support to patients, families and carers to minimise their distress and supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment.
- Staff gave patients practical support and advice to lead healthier lives. Complex care matrons provided health coaching for patients with long term health conditions to empowered them to manage their own conditions and to promote their own health.

However:

- The service did not always have enough staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. We found that most teams were in a better position with staffing than at our last inspection, however, some teams were still under pressure due to vacancies and high sickness levels. The service had mitigation in place to manage staffing issues.
- People could not always access the service when they needed it and did not always received the right care in a timely way. Therapy staff in the care networks were not able to see patients within the recommended timescale and there were still long waits for patients to be assessed in the continence service. This was identified as an issue at our last inspection.

Is the service safe?

Good  

Our rating of safe improved. We rated it as good because:

- The service used systems and processes to safely prescribe, administer, record and store medicines. The division had introduced a new pathway for prescribing governance and non-medical prescribers were now given the opportunity to discuss their prescribing history and report during supervision.
- The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.

Community health services for adults

- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.
- The service provided mandatory training in key skills to all staff and made sure everyone completed it. Mandatory training levels were good in community services for adults.
- Staff completed and updated risk assessments for each patient and removed or minimised risks. Staff identified and quickly acted upon patients at risk of deterioration. Staff had received training in the signs and symptoms of sepsis and were clear on what to do if they suspected sepsis.
- The design, maintenance and use of facilities, premises and equipment kept people safe. Staff managed clinical waste well. When providing care in patients' homes staff took precautions and actions to protect themselves and patients.
- Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date, stored securely and easily available to all staff providing care.

However:

- The service did not always have enough staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. We found that most teams were in a better position with staffing than at our last inspection, however, some teams were still under pressure due to vacancies and high sickness levels. The service had mitigation in place to manage staffing issues.
- There were not enough laptops supplied to staff in the service and some current laptops were very old and often in need of repair. This caused difficulty to staff when visiting patients in their homes as they were not able to access information they needed. The leadership team were aware of the issue and it was on the divisional risk register. Some additional laptops had been sourced and distributed and a business case was being developed to supply new laptops and smart phones.

Is the service effective?

Good  ➡ ➡

Our rating of effective stayed the same. We rated it as good because:

- The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance.
- The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development. Staff told us that supervision had improved since the last inspection.
- All those responsible for delivering care worked together as a team to benefit patients. They supported each other to provide good care and communicated effectively with other agencies.
- Staff gave patients practical support and advice to lead healthier lives. Complex care matrons provided health coaching for patients with long term health conditions to empowered them to manage their own conditions and to promote their own health.
- Staff supported patients to make informed decisions about their care and treatment. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health.
- Staff regularly checked if patients were eating and drinking enough to stay healthy and help with their recovery.

Community health services for adults

However:

- Therapy staff in the integrated care networks did not feel part of the integrated team. Although they shared the same office space as the community nurses which allowed for informal conversations about patients, they had separate monthly team meetings and information was not shared across all staff in the care network.

Is the service caring?

Good ● → ←

Our rating of caring stayed the same. We rated it as good because:

- Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.
- Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs.
- Staff supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment.

Is the service responsive?

Requires improvement ● → ←

Our rating of responsive stayed the same. We rated it as requires improvement because:

- People could not always access the service when they needed it and did not always received the right care in a timely way. Therapy staff in the care networks were not able to see patients within the recommended timescale. Data supplied by the service showed that the average time for an urgent physiotherapy referral to be seen in August 2019 ranged from 3.9 to 5.5 weeks was against a target of 48 hours. There were also long waits for patients referred to occupational therapist and dietitians.
- There were still long waits for patients to be assessed in the continence service. This was identified as an issue at our last inspection. Information provided to us at the time of the inspection showed there were a total of 142 patients waiting for assessment. The longest waiter was a patient needing a home visit who had been referred in February 2019. Staff told us they had set up a joint clinic to try and reduce the backlog of referrals and there had been some input from bank staff, however, they were still unable to meet the current demand.
- Community nursing service were not able to provide data on the time patients waited to be seen for an urgent or non urgent appointment. Although there were no waiting lists, they could not be assured that patients were being seen in a timely way to meet their needs. However, managers told us they had recently invested in a reporting system which could extract this data and they were in the process of validating data.

However:

- It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service received a low number of formal complaints and a high number of compliments.
- The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.

Community health services for adults

Is the service well-led?

Good ● ↑

Our rating of well-led improved. We rated it as good because:

- Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.
- The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. This was an improvement since our last inspection.
- Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear. However, morale was still low in some teams due to staffing levels.
- Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.
- Leaders and teams used available data to manage performance. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.
- Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.

However:

- We found that engagement with patients and relatives was limited and their views were not widely used to plan and develop services.
- The service did not always collect reliable data and analyse it. Staff could not find all the data they needed, in easily accessible formats, to understand performance, make decisions and improvements.

Areas for improvement

We found areas for improvement in this service. See the Areas for Improvement section above.

Community dental services

Good  

Key facts and figures

The community dental service operates from four community venues, Scunthorpe General Hospital and Diana, Princess of Wales Hospital. The service accepts referrals from a range of partners, providing active prevention, restorative treatment, periodontal and prosthetic care, minor surgery, including the extraction of teeth, treatment under sedation and general anaesthesia (GA) as appropriate, orthodontics in liaison with the surgical division, pain and anxiety management services to local needs and agreed priorities.

A service priority is the provision of oral health care to disadvantaged groups who cannot or do not use the general dental services (GDS). Children with extensive disease, from families who do not normally use the GDS and adults and children who are disabled and or have a compromising medical problem affecting their oral health and accessibility to dental services. The service provides domiciliary care to those who meet the criteria. The trust are the provider of treatment not generally available in the GDS.

Other key objectives of the service include oral health promotion. Programmes and activities are provided within the general aims set out in the oral health strategy and the specific aims as expressed in the oral health promotion section and epidemiological studies investigating the patterns of oral diseases in the local community (commissioned by the two Local Authorities).

The CDS provides both a dental public health and treatment service acting in a complimentary way to the hospital and general dental practitioners to meet the needs of the population of Northern Lincolnshire.

Information about the sites and teams, which offer community dental services at this trust, is shown below:

Location / Address Services provided

Ashby Clinic, Collum Lane, Scunthorpe, North Lincolnshire, DN16 2SZ

Cleethorpes Primary Care Centre, Cleethorpes, North East Lincolnshire, DN35 8EE

Cromwell Primary Care Centre, Cromwell Road, Grimsby, North East Lincolnshire, DN31 2BH

Ironstone Centre, West Street, Scunthorpe, North Lincolnshire, DN15 6EG

Trust staff offer dental care to children with high levels of dental problems, people with special needs and the elderly. Wheelchair users and bariatric patients can also be accommodated and there are facilities to offer conscious sedation and general anaesthetic. Staff will, where necessary, undertake home visits. Priority in the provision of oral health care is given to those disadvantaged groups who cannot or do not use the general dental service, this includes children with extensive disease, children from families who do not normally use the general dental service, adults and children who are disabled and or have a compromising medical problem which can both affect their oral health and the accessibility to dental services. Patients with special needs includes those with physical disabilities, learning difficulties and mental health problems for whom dental care in the mainstream services is difficult as well as medically compromised patients needing dental care.

We received feedback from nine patients and spoke with 13 members of staff. We looked at dental care records for ten people.

Our inspection between 24 and 27 September 2019 was announced (staff knew we were coming) to ensure that everyone we needed to talk to was available. During the inspection we visited all community locations where dental services are provided from. The services were located in Scunthorpe, Grimsby and Cleethorpes.

Community dental services

Summary of this service

Our rating of this service improved. We rated it as good because:

- The service had enough staff to care for patients and keep them safe. Staff had training in key skills, understood how to protect patients from abuse, and managed safety well. The service controlled infection risk well. Staff assessed risks to patients, acted on them and kept good care records. They managed medicines well. The service managed safety incidents well and learned lessons from them. Staff collected safety information and used it to improve the service.
- Staff provided good care and treatment in line with nationally recognised guidance. Managers monitored the effectiveness of the service and made sure staff were competent. Staff worked well together for the benefit of patients, advised them on how to lead healthier lives, supported them to make decisions about their care, and had access to good information.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. They provided emotional support to patients, families and carers.
- The service planned care to meet the needs of local people, took account of patients' individual needs, and made it easy for people to give feedback. People could access the service when they needed it and did not have to wait too long for treatment.
- Leaders ran services well using reliable information systems and supported staff to develop their skills. Staff understood the service's vision and values, and how to apply them in their work. They were focused on the needs of patients receiving care. Staff were clear about their roles and accountabilities. The service engaged well with patients and the community to plan and manage services and all staff were committed to improving services continually.

However:

- Staff morale was low within the service. This was due to a protracted re-structuring process.
- Patient's post-operative blood pressure was not always recorded in the dental care records following intravenous sedation.
- There had been some issues with the boiler at Cromwell Primary Care Centre. This had led to a lack of hot water for four days on one occasion. There had been a delay in reporting this as a significant event.

Is the service safe?

Good  

Our rating of safe improved. We rated it as good because:

- The service provided mandatory training in key skills to all staff and made sure everyone completed it.
- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.
- The service controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.

Community dental services

- The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well.
- Staff completed and updated risk assessments for each patient and removed or minimised risks. Staff identified and quickly acted upon patients at risk of deterioration.
- Staff had the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix.
- Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date, stored securely and easily available to all staff providing care.
- The service used systems and processes to safely prescribe, record and store medicines.
- The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.

However:

- There had not been any hot running water at Cromwell Primary Care Centre. This had been identified through an infection prevention and control audit. This had not been recorded as a significant event.

Is the service effective?

Good   

Our rating of effective stayed the same. We rated it as good because:

- The service provided care and treatment based on national guidance and evidence-based practice. Staff protected the rights of patients in their care.
- Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients.
- The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development.
- All those responsible for delivering care worked together as a team to benefit patients. They supported each other to provide good care and communicated effectively with other agencies.
- Staff gave patients practical support and advice to lead healthier lives.
- Staff supported patients to make informed decisions about their care and treatment. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health.

However:

- Patient's post-operative blood pressure was not always recorded in the dental care records following intravenous sedation.

Community dental services

Is the service caring?

Good   

Our rating of caring stayed the same. We rated it as good because:

- Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.
- Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs.
- Staff supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment.

Is the service responsive?

Good   

Our rating of responsive stayed the same. We rated it as good because:

- The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.
- The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.
- People could access the service when they needed it and received the right care in a timely way.
- It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint.

Is the service well-led?

Good  

Our rating of well-led improved. We rated it as good because:

- Leaders had the integrity, skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.
- The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.
- Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

Community dental services

- Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.
- The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.
- Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.
- All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.

However:

- Staff morale was low within the service. This was due to a protracted re-structuring process involving the dental nurses. This had led to a division between the dental nurses and the organisation. The issues with staff morale were not on divisional risk register.

Outstanding practice

Areas for improvement

We found areas for improvement in this service. See the Areas for Improvement section above.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that the service provider was not meeting. The provider must send CQC a report that says what action it is going to take to meet these requirements.

For more information on things the provider must improve, see the Areas for improvement section above.

Please note: Regulatory action relating to primary medical services and adult social care services we inspected appears in the separate reports on individual services (available on our website www.cqc.org.uk)

This guidance (see goo.gl/Y1dLhz) describes how providers and managers can meet the regulations. These include the fundamental standards – the standards below which care must never fall.

Regulated activity

Treatment of disease, disorder or injury

Regulation

Regulation 9 HSCA (RA) Regulations 2014 Person-centred care

Regulated activity

Treatment of disease, disorder or injury

Regulation

Regulation 11 HSCA (RA) Regulations 2014 Need for consent

Regulated activity

Treatment of disease, disorder or injury

Regulation

Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

Regulated activity

Treatment of disease, disorder or injury

Regulation

Regulation 16 HSCA (RA) Regulations 2014 Receiving and acting on complaints

Regulated activity

Treatment of disease, disorder or injury

Regulation

Regulation 17 HSCA (RA) Regulations 2014 Good governance

Regulated activity

Regulation

This section is primarily information for the provider

Requirement notices

Treatment of disease, disorder or injury

Regulation 18 HSCA (RA) Regulations 2014 Staffing

Regulated activity

Regulation

Treatment of disease, disorder or injury

Regulation 5 HSCA (RA) Regulations 2014 Fit and proper persons: directors

Our inspection team

Sarah Dronsfield, Head of Hospitals Inspection led this inspection. An executive reviewer, Roy Clarke, supported our inspection of well-led for the trust overall.

The team included 3 inspection managers, 24 inspectors, an executive reviewers, 36 specialist advisers, and 1 expert by experience.

Executive reviewers are senior healthcare managers who support our inspections of the leadership of trusts. Specialist advisers are experts in their field who we do not directly employ. Experts by experience are people who have personal experience of using or caring for people who use health and social care services.